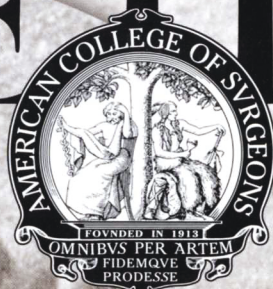


BULLETIN

AMERICAN COLLEGE OF SURGEONS



May 2001
Volume 86, Number 5

The changing landscape
of rural surgery



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About the cover...

Surgical practice in rural Pauls Valley, OK, has been a way of life for the Lindsey family for more than 100 years. This month's cover illustrates this legacy with a photo of Harvey Lindsey, MD, FACS, on his way to see a patient and an inset featuring grandson James Lindsey, MD, FACS, talking with a current patient and a medical student. Dr. Lindsey is one of three surgeons in Oklahoma who share their perspectives on the pros and cons of the changing landscape of rural surgery (p. 14).

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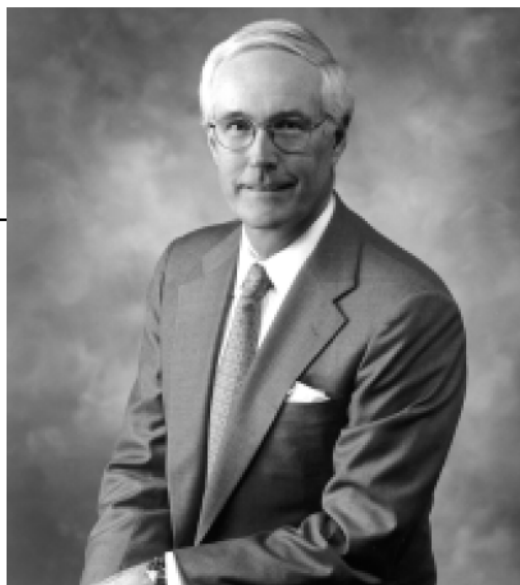
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From my perspective



Capitated fees and corporate control of health care decisions have generated a strong sense of frustration among all physicians. In their efforts to regain control over decision making and their financial futures, surgeons have looked for ways to at least negotiate with managed care plans and other insurers. The problem is they often find that they as individuals can do little to change the policies of the huge corporate entities that provide coverage to most patients.

As a result, a movement toward collective bargaining and even unionization has been building over the last decade. Although we have yet to persuade Congress to pass a law that would allow independent physicians to negotiate the terms of their contracts with insurers, one particularly proactive coalition of surgeons in Washington State has successfully demonstrated that collective bargaining can work.

Why collective bargaining is needed

I think it's important to reflect on the factors that have driven generally individualistic surgeons to consider collective bargaining as a means of coping with the modern health care system.

In the 1980s, managed care organizations of various sizes sprung up throughout the country. As is common among all industries, smaller, less competitive plans merged with or were swallowed up by bigger, more aggressive companies. As a result, the health insurance industry has become incredibly monopolistic. In fact, recent reports indicate that six insurers currently dominate the health care system. Surgeons often feel that they must concede to the demands these corporations place on them or lose patients.

The market domination that these huge insurance companies wield has created major problems for both physicians and their patients. Terms established in contracts with large health plans often stretch beyond the limits that any reasonable and ethical professional could tolerate. Capitated fees are really just one part of the problem. Putting patients at risk for possibly receiving lower quality of care because of decisions that are motivated by the bottom line rather than medical needs is another serious byproduct of the corporatization of health care. On a truly dictatorial level, surgeons have been confronted with "all products" clauses,

“It’s not surprising that surgeons and other physicians want to band together and present a united front to the insurance companies.”

which have forced physicians to accept unfavorable contract terms or risk prohibition from treating any patient covered by the plans, and “gag clauses,” which have prohibited physicians from discussing certain treatment options with their patients. Arbitrary length of stay is yet another mandate that has made it difficult for surgeons to make certain their patients receive adequate care.

A certain proportion of physicians who are unwilling to compromise their integrity and give into unrealistic, inequitable, unjust demands are refusing to participate in certain plans. This reaction, in turn, creates an access problem for patients and potentially diminishes quality of care.

Attempts at legislative relief

Given these circumstances, it's not surprising that surgeons and other physicians want to band together and present a united front to the insurance companies. Unfortunately, federal antitrust laws hinder the ability of medical and surgical organizations and individual surgeons to establish these coalitions.

Former U.S. Rep. Tom Campbell (R-CA) and Rep. John Conyers, Jr. (D-MI), introduced a bill in the

106th Congress that would have alleviated antitrust pressures by permitting independent physicians to negotiate collectively with their health plans. The College supported this legislation, and an amended version of the bill passed in the House. However, strong opposition from Senate Republican leaders prevented further action.

Representative Campbell lost his House seat when he ran against and lost to Sen. Dianne Feinstein (D-CA). Representative Campbell was the major congressional champion of collective bargaining legislation. During the ACS Spring Meeting, he pledged to continue his efforts.

Success story

The College intends to continue to support legislation that would allow self-employed physicians to engage in collective negotiating. But, surgeons should not assume that there is nothing they can do about unfair contract clauses until such legislation is enacted. Indeed, a cadre of practicing surgeons in the state of Washington have already shown that collective bargaining can work under the current circumstances.

By the middle to late 1990s, surgeons in Washington had experienced a 30 percent reduction in fees over recent years due to decreasing payments from the major health plans serving the greater Seattle area. A group of orthopaedic surgeons were the first to react by forming a single business that would work with insurers to achieve reasonable reimbursement rates and contract terms. A group of general surgeons soon followed, according to Robert Howisey, MD, FACS, who helped to establish Surgical Associates of Washington in January 1998.

Surgical Associates of Washington comprises 40 general surgeons from 11 care centers in the Seattle area. To comply with federal antitrust mandates, this entity was set up as a professional services corporation. All the members are shareholders in a single business, which filed for a single tax identification number, signed with a single malpractice carrier, and developed a single pension plan for all members. Also, to abide by the federal rules, only 30 percent of the general surgeons in the area were asked to participate in the venture during its start-up phases. This stipulation in the federal statutes ensures that any one business does not attain control of most of the marketplace.

In order to participate in the firm, general sur-

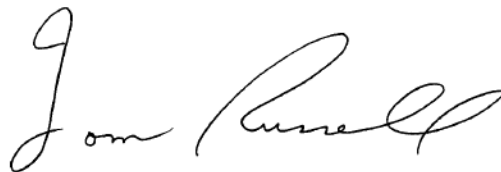
geons had to have a proven track record of providing high-quality surgical services and be Fellows of the College. After two years of unsuccessful discussions and meetings with insurers, the members of the group agreed to collectively drop their contracts with insurers that were placing unfair pressures on them and their patients, starting with the largest insurer in the area. At first, the insurer refused to yield to the group's demands, but when patients started dropping out of the plan because they didn't have access to the surgeons, the insurer agreed to head to the bargaining table. Dr. Howisey says that by "turning the tide" with the largest insurer, the surgeons were able to start negotiations with other plans, as well. The participating general surgeons are now experiencing a 10 percent increase in payment.

The group in Seattle intends to continue to stay in business and work together on contracting and other important health care issues, such as quality improvement and best practices, starting with clinical guidelines for colon resections.

Much to learn

I was so impressed with Dr. Howisey's story that I have asked him to write an article about his group and their experiences for publication in an upcoming issue of the *Bulletin*. I believe that all surgeons who are interested in collective bargaining will learn a lot from him about this process.

I also hope that other surgeons who have engaged in similar efforts or who have other ideas about how to address problems in health insurance contracts will be encouraged to share their stories and thoughts with me and with the Fellowship. By taking a proactive stance and thinking "outside the box," we might be able to stop the mega-corporations from controlling the quality of care we can provide to our patients.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.

FYI: *STAT*

This column provides brief reports on important items of interest to members of the College. It will appear in the Bulletin when there is "hot news" to report. In-depth coverage of activities announced here will appear in columns and features published in the Bulletin and in the College's weekly electronic newsletter, ACS NewsScope.



Dr. Russell and other College representatives participated in the annual scientific meeting of the **Society of American Gastrointestinal and Endoscopic Surgeons** (SAGES) in St. Louis, MO, April 18-21. In his plenary lecture, Dr. Russell addressed "ACS & SAGES: Joint Activities to Improve Patient Care." Other College representatives at the meeting were Frederick Greene, MD, FACS, Chair of the Governors' Committee on Surgical Practice in Hospitals; Charles Mabry, MD, FACS, and Frank Opelka, MD, FACS, members of the General Surgery Coding and Reimbursement Committee; and Cynthia Brown, Director of the Health Policy and Advocacy Department.



On April 4, Fellows from the Brooklyn-Long Island, Kansas, and New Jersey chapters visited Capitol Hill as part of the College's **Chapter Visit Program**. Each chapter met with legislators from their respective congressional delegations and discussed a number of issues on the College's legislative agenda, including support for: passage of a strong Patients' Bill of Rights; increased funding for state trauma system development; and enactment of the Medicare Education and Regulatory Fairness Act.



The College has developed a program through which **Fellows can update and edit their individual online directory listings**, including addresses, telephone and fax numbers, and e-mail addresses. In addition, Fellows can elect to add more detailed information about their practices, including areas of special interest. To update your current directory listing, visit the ACS Web site at <http://www.facs.org> and click the "Members Only" link. You will need your eight-digit College ID number, which can be found on the back of your Fellow Identification card or on your address label on the back of the *Bulletin*. Your updated Fellowship record will automatically be entered in the College's membership database. There is no need to also notify the College offices about your updated information.



The American College of Surgeons will present one-day workshops in May and June on **CPT and ICD-9-CM basic to intermediate coding** for surgeons and their administrative and office staffs. They will be held May 10 (Dayton, in conjunction with Ohio Chapter meeting), May 27 (San Francisco, CA), June 9 (San Juan, PR), June 22 (Chicago, IL), and June 23 (Delavan, WI). For registration information, contact dmazmanian@facs.org.

Dateline Washington

prepared by the Health Policy and Advocacy Department

Bush unveils 2002 budget plan

President Bush released the details of his fiscal year (FY) 2002 budget, *A Blueprint for New Beginnings*, on April 9. The plan, which outlines the new administration's spending priorities and policy reforms for the coming fiscal year, proposes a strict 4 percent cap on increases in discretionary spending. The President does, however, exempt a few selected programs from the cap, including health research funding and certain programs under the Department of Defense.

Among other things, the Bush budget proposal would: provide a \$2.8 billion increase in funding for the National Institutes of Health; increase spending for Community Health Centers by \$124 million as part of a multiyear initiative to increase the number of center sites by 1,200; support greater funding for the Agency for Healthcare Research and Quality; reform the National Health Service Corps; and provide an immediate prescription drug benefit to Medicare beneficiaries over the next four years while Congress addresses comprehensive program reforms. Of particular interest to surgeons, President Bush proposes to reduce fraud and abuse within the Medicare program by increasing funds for the Health Care Financing Administration's (HCFA's) Medicare Integrity Program and for the Department of Health and Human Services' Office of the Inspector General. He also proposes to implement new Medicare "user fees" of \$1.50 for all paper claims, as well as for duplicate and "unprocessable" claims that are filed.

Finally, the Administration's FY 2002 budget includes \$2 million in funding for trauma and emergency medical services systems. Last year, the College was successful in persuading Congress to approve \$3 million in FY 2001 funding for the Trauma Care Systems Planning and Development Act. Funding for the program was publicly supported last year by a bipartisan group of 55 senators and 114 representatives.

Health care spending growth remains low

Spending for health care in the U.S. exceeded \$1.2 trillion in 1999, up 5.6 percent from 1998, but continued a six-year trend of growth below 6 percent, according to a report issued by HCFA on March 12. The agency predicts faster growth over the next decade, although not at the high rates experienced in the 1980s and early 1990s.

Between 1993 and 1999, health spending nationally averaged increases of 0.5 percentage points less than the gross domestic product (GDP) as the shift to managed care and impacts on Medicare spending from the Balanced Budget Act (BBA) of 1997 resulted in one-time savings. Coupled with faster real growth in the economy, this savings caused a slight decline in health spending's share of GDP, from 13.4 percent in 1993 to 13.0 percent in both 1998 and 1999. Health care spending is projected to consume a growing share of GDP in coming years, however, up to 15.9 percent in 2010. The key factors behind this expected trend include the projected economic slowdown, continued advances in medical technology, and the inability of insurers to sustain the initial cost savings that resulted from the shift to managed care.

Currently, annual growth in Medicare spending remains low—only 0.1 percent in 1998, and 1.0 percent in 1999—well below the 9.2 percent average recorded for 1993-1997. The two-year slowdown is attributed primarily to the effects of changing payment systems for home

Medicare issues new coverage decisions

health care facilities and nursing homes, slower growth in general health care costs, and continuing federal government efforts to detect and reduce fraud and abuse. Medicare spending growth is projected to accelerate through the remainder of the decade, however.

Growth in spending for prescription drugs continued to outpace spending growth for other health services in 1999, with increases of 16.9 percent. Drug costs are expected to continue increasing at an average rate of 12.6 percent between 1999 and 2010.

Full information on the HCFA national health expenditures reports was published in the March/April 2001 issue of *Health Affairs*, a publication of Project Hope. The article is accessible on the journal's Web site, www.healthaffairs.org.

On March 20, HCFA announced that Medicare will cover angioplasty of the carotid artery with stent insertion, a new treatment option for the prevention of stroke, under certain conditions. After a review of the scientific and clinical evidence, the agency determined that the evidence regarding carotid stenting concurrent with angioplasty, and the Food and Drug Administration's willingness to approve certain IDE trials involving carotid stents, are sufficient to provide limited access to this technology. Detailed information about the coverage decision is posted on HCFA's Web site at <http://www.hcfa.gov/coverage/8b3-rr.htm>.

HCFA announced in April that Medicare would provide coverage for intestinal transplants for patients with irreversible intestinal failure. The agency has selected and approved three transplant centers to perform the procedure, based on their demonstrated experience and successful outcomes: University of Pittsburgh Medical Center, Jackson Memorial Hospital Transplant Center in Miami, and Mt. Sinai Hospital in New York. Additional information on this coverage policy may be found at <http://www.hcfa.gov/news/pr2001/pr010401.htm>.

MedPAC recommends GME reforms to Congress

In its March 2001 report to Congress, the Medicare Payment Advisory Commission (MedPAC) argued that Medicare's payment policies should not be used to influence the specialty mix of the physician workforce and that the current set of weighting factors used to determine direct graduate medical education (GME) payments seem to be an attempt to do just that. Currently, Medicare limits full GME support to the time required for a resident to complete an "initial residency period" of up to five years; additional time spent in specialty training is only half-funded.

MedPAC recommended that Congress eliminate the weighting factors and count all residents equally through completion of their first specialty or combined program, and through subspecialty training as well. The commission noted that these policy changes could be implemented in a budget-neutral manner through adjustments to the per resident payment amounts. Without a "budget neutrality" requirement, MedPAC estimates that eliminating the weighting factors could increase Medicare's direct GME payments by 5 to 8 percent. The full text of the report may be viewed on MedPAC's Web site at www.medpac.gov.

What surgeons should know about...

Late, partial, or denied payment or lost claims

by Diane Krier-Morrow, Manager, Chicago Staff, Health Policy and Advocacy Department

One of the problematic issues in practice management is the fact that payments from third-party payors are either late or partial or claims are ignored or lost. Practices report significant problems with denied payments, especially when new *Current Procedural Terminology* (CPT) or *International Classification of Diseases, 9th Edition, Clinical Modification* (ICD-9-CM) codes are introduced and payors' computers are not programmed appropriately to pay for new codes.

Timely payment of health insurance claims has become a widespread issue within the arena of medical claims processing and adjudication. Tracking claims processing and the aging of your accounts receivable are good business practices. Developing a practice compliance plan, as guidelines recently suggest, looking at the reimbursement systems within your individual practice setting—solo, small group, large group, academic, and so on—just makes good business sense.

Medical billing and claims processing are systems that are vital to the cash flow in a practice. Indeed, the problem has become so severe that there have been more and more reports of physicians taking out loans to cover their practice expenses, estimated to be about 40 to 50 percent of surgical gross production.

The purpose of this article is to provide guidance on how to react to late, partial, or denied payment or lost claims. Coding and reimbursement issues and trends often are among the topics surgeons most frequently discuss. In fact, when two or more gather and are discussing

nonclinical, socioeconomic topics, reimbursement is often at the top of the list.

Q. Why does it take so long for me to receive payment for my services?

A. No other industry contends with the problems that physicians face with receiving timely reimbursement for their work. While prompt payment laws have been enacted in 41 states to advocate for timely payment to physicians for the services and procedures they provide, at press time, nine states and the District of Columbia had not enacted prompt payment laws, but seven had legislation pending. The American College of Surgeons, along with all other medical and surgical specialty organizations, supports timely payment of medical insurance claims. State chapters are encouraged to work with their state medical societies and surgical specialty organizations to advocate for legislation requiring prompt payment. Also, chapters are encouraged to monitor their local insurance plans to be certain they are obeying their state regulations regarding prompt payment. It is important to collect data at the local level to determine which insurers are not paying claims within the timeline required under the regulation and, specifically, how late they are paying. Many of the enacted laws provide a specific timeline, such as within 30 or 45 days. Data need to be collected when these timelines are being exceeded. We also encourage surgeons to work with their state attorneys general and insurance commissioners to seek redress and collect interest payments for delayed claims.

Q. What is prompt payment?

A. Prompt payment depends on the individual interpretations of all your third-party payors, including Medicare, Medicaid, TRICARE, managed care, and other sources of revenue. A recent communication from Medicare defined prompt payment as reimbursement within 30 days of the receipt of a clean claim. Payment timelines should be addressed in your individual managed care contracts. Staff should develop a listing of these timelines, which need to be tracked by your practice administrator or billing staff. If payment should be received in 30 days, on day 31 staff should contact your provider representative on nonreceived payment. Managed care contracts should spell out interest rates for late payments.

Q. How do I begin to track my accounts receivable?

A. Some surgeons have reported that they have only recently begun to pay attention to the business side of practice. Many report that they have left the accounts receivable (A/R) to their administrative and billing staff or outside medical billing companies. If you have not been tracking your A/R, it is time to develop a system to track A/R monthly. One of the first steps is to list by month your gross charges, contractual write-offs, net receipts, total accounts receivable from insurers, the change in A/R, and the percentage A/R over 90 days. Be sure to count the aging of your A/R from the date of service, not the date you filed the claim with the insurer. Many practices bill electronically. When you have collected these data, compare months from year to year.

Q. What do you recommend for collection of copays?

A. List your top 20 procedures and known payment from your major payors. It is important to include evaluation and management codes, not just surgical procedures, in your top 20 procedures. The table on pages 10 and 11 lists the top 50 CPT codes billed to Medicare by U.S. general surgeons based on the most available 1999 national utilization data.

If not already a practice, institute a policy that patients will be asked about deductibles and copays, and that copays and deductibles will be collected at the initial visit. Staff can be trained to explain your collection policy during the first telephone encounter when they are scheduling the appointment. A brochure can be developed outlining the practice's collection policy, including your expectations for payment.

Q. Why would I receive a late or inappropriate payment?

A. It has also been reported that insurers are ignoring or losing claims, as well as down-coding or bundling payments, even when claims are filed electronically. Some billing companies have reported that up to 30 percent of claims are reported to have not been received. The College is working on a resolution to the American Medical Association for their annual meeting in June, stating that insurers cannot deny payment on lost claims when the physician has proof that the claim was filed electronically, if beyond the required filing date. This requirement is being added to some prompt payment laws.

The College also has received reports of partial or down-coded payments received from third-party payors who bank on many billing staff writing off the difference. It is also important for you and your staff to learn the appropriate use of evaluation and management codes to ensure full payment for services provided. It has been reported that surgeons give away their evaluation and management

**Top 50 CPT codes billed Medicare by United States general surgeons
(sorted by CPT code)***

Alwd chrg rank	CPT	Descriptor	1999 Medicare utilization	2001 MFS nonfac RVU	2001 MFS nonfac payment	2001 MFS facility RVU	2001 MFS facility payment
27	19120	Excision, breast lesion(s), male/female; 1+	51,271	10.22	\$391.00	9.62	\$368.04
22	19125	Excision, breast lesion, radiological marker; single	52,674	11.24	430.02	10.29	393.68
34	19162	Mastectomy, partial; w/ axillary lymphadenectomy	16,316	n/a	n/a	23.52	899.83
13	19240	Mastectomy, modified radical, w/ axillary lymph nodes	32,596	n/a	n/a	26.93	1,030.29
38	27590	Amputation, thigh, through femur, any level	15,759	n/a	n/a	25.25	966.02
32	33533	Coronary artery bypass, using arterial graft(s); single arterial graft	12,265	n/a	n/a	51.36	1,964.94
46	35081	Repair direct/false aneurysm/excision & graft insert; abdominal aorta	8,322	n/a	n/a	46.59	1,782.44
4	35301	Thromboendarterectomy, w/wo patch graft; carotid, vertebral, subclavian, neck incision	50,886	n/a	n/a	32.10	1,228.09
37	35656	Bypass graft, w/ other than vein; femoral-popliteal	11,959	n/a	n/a	33.41	1,278.20
39	36489	Placement, central venous catheter, percutaneous, > age 2	135,971	4.08	156.09	2.12	81.11
9	36533	Insertion, implantable venous access device w/wo subcutaneous reservoir	97,469	10.22	391.00	9.61	367.66
15	36830	Creation, av fistula, non-direct (sep proc); non-autogenous graft	31,156	n/a	n/a	20.91	799.98
50	36832	Revision, av fistula; w/o thrombectomy, dialysis graft (sep proc)	6,972	n/a	n/a	17.98	687.88
31	43239	Upper gi endoscopy; w/ bx, single/multiple	74,283	7.48	286.17	4.59	175.60
40	44005	Enterolysis (freeing, intestinal adhesion) (sep proc)	15,842	n/a	n/a	22.51	861.19
19	44120	Enterectomy, resection, small intestine; single resection & anastomosis	27,498	n/a	n/a	23.73	907.86
3	44140	Colectomy, partial; w/ anastomosis	61,999	n/a	n/a	29.88	1,143.15
21	44143	Colectomy, partial; w/ end colostomy & closure, distal segment	17,523	n/a	n/a	34.55	1,321.82
20	44145	Colectomy, partial; w/ coloproctostomy (low pelvic anastomosis)	18,156	n/a	n/a	37.27	1,425.88
29	44160	Colectomy w/ removal, terminal ileum & ileocolostomy	17,321	n/a	n/a	26.69	1,021.11
10	45378	Colonoscopy, flexible, proximal to splenic flexure; dx, w/wo specimens/colon decomp (sep proc)	111,971	9.95	380.67	6.26	239.50
48	45380	Colonoscopy, flexible, proximal to splenic flexure; w/ bx, single/multiple	35,885	10.58	404.77	6.75	258.24
24	45385	Colonoscopy, flexible; w/ removal, lesion, snare	44,954	13.03	498.50	8.85	338.58
1	47562	Repair, initial incisional/ventral hernia; reducible	34,411	n/a	n/a	16.57	633.94
5	47563	Renal allotransplantation, implantation, graft; w/o donor & recipient nephrectomy	5,621	n/a	n/a	54.44	2,082.77
26	47600	Laparoscopy, surgical; cholecystectomy	108,506	n/a	n/a	18.17	695.15
6	49505	Laparoscopy, surgical; cholecystectomy w/ cholangiography	61,416	n/a	n/a	19.59	749.48
23	49560	Cholecystectomy	32,989	n/a	n/a	19.24	736.09
43	50360	Repair, initial inguinal hernia, age 5+; reducible	91,157	11.49	439.59	11.16	426.96
28	93880	Duplex scan, extracranial arteries; complete bilat study	191,014	4.94	189.00	4.94	189.00
36	99203	Office outpatient visit, new patient, level 3	165,108	2.39	91.44	1.87	71.54

continued on next page

**Top 50 CPT codes billed Medicare by United States general surgeons
(sorted by CPT code)* (continued)**

Alwd chrg rank	CPT	Descriptor	1999 Medicare utilization	2001 MFS nonfac RVU	2001 MFS nonfac payment	2001 MFS facility RVU	2001 MFS facility payment
45	99204	Office outpatient visit, new patient, level 3	92,639	3.47	132.76	2.76	105.59
7	99212	Office outpatient visit, established patient, level 2	1,183,492	0.94	35.96	0.64	24.49
2	99213	Office outpatient visit, established patient, level 3	1,529,634	1.32	50.50	0.93	35.58
8	99214	Office outpatient visit, established patient, level 4	527,768	2.06	78.81	1.51	57.77
47	99215	Office outpatient visit, established patient, level 5	101,286	3.06	117.07	2.43	92.97
44	99222	Initial hospital care, level 2	90,372	n/a	n/a	3.07	117.45
35	99223	Initial hospital care, level 3	82,498	n/a	n/a	4.20	160.68
16	99231	Subsequent hospital care, level 1	648,925	n/a	n/a	0.94	35.96
12	99232	Subsequent hospital care, level 2	495,211	n/a	n/a	1.50	57.39
33	99233	Subsequent hospital care, level 3	164,785	n/a	n/a	2.13	81.49
25	99242	Office consultation, level 2	214,672	2.34	\$89.52	1.85	70.78
11	99243	Office consultation, level 3	280,438	3.09	118.22	2.46	94.11
17	99244	Office consultation, level 4	156,487	4.38	167.57	3.61	138.11
42	99245	Office consultation, level 5	55,851	5.73	219.22	4.79	183.26
41	99252	Initial inpatient consultation, level 2	143,282	n/a	n/a	2.03	77.66
18	99253	Initial inpatient consultation, level 3	221,853	n/a	n/a	2.74	104.83
14	99254	Initial inpatient consultation, level 4	171,043	n/a	n/a	3.88	148.44
30	99255	Initial inpatient consultation, level 5	71,432	n/a	n/a	5.31	203.15
49	99291	Critical care, evaluation & management, first 30-74 minutes	43,486	5.71	218.45	5.52	211.18

*All specific references to CPT terminology and phraseology are: CPT only © 2000 American Medical Association. All rights reserved.

charges. It is also important to learn the appropriate use of modifiers that are now all listed in Appendix A of the CPT book. Previously, modifiers were listed in the E/M section and surgery section of the CPT book. Make sure that your staff appends E/M modifiers to E/M codes, and surgical modifiers to surgical codes. Using modifiers with the incorrect codes will result in denials.

Q. Insurers are complaining that nearly half of the claims they receive are coded incorrectly. What is a “clean” claim?

A. The College has heard that complaint as well. Medicare defines a clean claim as one that has no defect or impropriety (including any lack of any required substantiating documenta-

tion) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim (Section 1842(c)(2) of the Social Security Act). Many individuals believe this definition gives the payors too much flexibility. It is important that claims are completed properly with all identifying information, including appropriate ICD-9-CM diagnostic codes and CPT procedural codes with correct use of modifiers to ensure payment. It is important to provide training for staff regarding any changes related to coding and to monitor their performance for accurate and full completion of medical claim forms. Training and education are part of any practice compliance plan. For example, when Y2K problems were a concern, many insurers required reporting years with four digits, instead of only the last two. Billers need to

be trained and monitored on this and all changes that affect submission of clean claims.

Train staff to update patient information frequently and to request copies of current insurance cards. For instance, the College's staff health insurance plan recently changed the policy number, which, if not given to physician billing staff, could result in denied claims and delayed payment of four to six weeks. Some practices submit claims electronically to clearinghouses, which use scrubber software that return incomplete claims for missing information before they are filed. If you are still filing paper claims, you may be facing several weeks of delayed payment for denied claims. Also, with multiple procedures performed on the same day, the simple selection of a wrong modifier would delay payment for the entire claim, not just the procedure involved.

Q. After doing all the right tracking of medical claims in your practice, you notice certain trends among various insurers. What should you do?

A. The first thing to do with a partial payment, payment that the insurer has down-coded, or a denied claim is to appeal it, following the insurer's process for doing so. It is important to track that your staff or your billing company is not just writing off partial payments or inappropriately denied claims. For late or lost claims, communicate the trend to your national, regional, local, and state medical associations. Discuss trends at your chapter meetings to alert colleagues of your findings. It never hurts to designate a delegation to meet with a local carrier, with substantiating sample Explanation of Benefit (EOB) forms, when trends are identified. If you hear of some new coding practice in the doctor's lounge, check it out before you adopt an inappropriate or a fraudulent coding practice.

For lost and late payments or other improper

insurer policies, Fellows and their practice staff should contact their state department of insurance. The National Association of Insurance Commissioners, which is the organization of insurance regulators for the 50 U.S. states, the District of Columbia, and the four U.S. territories, oversees the \$900 billion insurance industry. Their Web site provides a listing of the state commissioners: <http://naic.org>.

Q. Medicare's Carrier Advisory Committee (CAC) meetings are held quarterly at the state level. I understand that the College is taking a proactive role in meeting with surgical CAC representatives. What can CAC representatives do?

A. Your state surgical representatives to Medicare's Carrier Advisory Committees meet with the state Medicare medical director and staff who work on coverage issues. CACs are mandated to work on coverage issues at the local level. The College has identified and met with many of the state surgical CAC representatives. However, with some representatives changing yearly, we are having difficulty keeping a current list to invite them to meetings. Please keep us informed of your current CAC representatives.

A College meeting of surgical CAC representatives is planned for October 7, so these representatives may meet and discuss issues of importance to surgeons. We have been tracking problems in some states with payment of preoperative consultations, ultrasounds, and assistants at surgery.

Q. How can the College assist Fellows with coding and reimbursement issues?

A. The College's Health Policy and Advocacy Department has as one of our primary goals to assist surgeons and their practices with

all practice management issues, including prompt payment. The College supports a CPT coding hotline (1-800/ACS-7911), and sponsors coding workshops throughout the year (for a list of locations visit the department's Web page at www.facs.org). We are also evaluating our practice management assistance to Fellows and their staffs and welcome your input.

The College has actively promoted correct coding by providing the coding hotline and workshops to assist Fellows and their staffs. This College-sponsored training and education program promotes submission of clean claims with the ultimate goal of ensuring that surgeons receive appropriate reimbursement for the procedures and services they provide. At a recent coding program, a participant stated that he has been under-coding excisions and repairs. He left the program stating that the College program saved his larger practice at least a half-million dollars! In addition, the College's *Bulletin* has a column, "Socioeconomic tips of the month," which addresses coding questions and practice management issues.

The College, as an umbrella organization for all surgeons, works closely with the other national surgical associations on coding and reimbursement issues. As explained in previous issues of the *Bulletin*, the College has organized and convened meetings with national insurers. We have met with the national Blues association and with CIGNA. We plan to meet with other insurers. In order to make the most of our visits, we need *one* sample of repeatedly denied claims, the EOB, and any correspondence related to having the claim paid.

Additionally, the College discussed the planned 2002 *Study on Physicians as Assistants at Surgery* at the March Surgical Specialty Society meeting to begin preparation for the study. The College receives reports that the 1999 study has been helpful in reversing denials for physicians as assistants for surgical procedures.

Further, the HPA Department has a State Af-

fairs Associate who tracks and monitors state legislation and periodically publishes health policy briefs on timely topics that are distributed to the College leadership; they are available on the College's Web site under HPA departmental publications. A *Health Policy Brief* was published on timely payment of health insurance claims. Contact Jon Sutton at jsutton@facs.org or 312/202-5358 for additional information.

The Health Policy and Advocacy Department stands ready to assist Fellows and their staffs with coding and reimbursement issues. Prompt payment of medical claims is the lifeblood of the surgical practices that are owned and operated by the Fellows we serve. 

*The changing landscape of rural surgery:
The view from Oklahoma*

by
Diane S. Schneidman,
Senior Editor



Rural life and surgical practice aren't quite what they used to be. While the American population continues to grow, the number of individuals residing in nonmetropolitan areas is slowly shrinking. The April 1994 *Bulletin* reported that 55 million people lived in rural America; 1998 data from the U.S. Office of Management and Budget indicate that the nonmetropolitan population dropped to 51 million in just four years.¹ Superstores have displaced the little "mom and pop" shops that previously dotted village main streets. The information superhighway and interstate roadways allow surgeons to interact with their colleagues across the country and to quickly transport patients in need of specialized care to larger in-state medical centers.

This article seeks to update surgeons on the changing realities of small-town practice as seen through the eyes of three surgeons in rural Oklahoma:

- John A. Buie, MD, FACS, a young general surgeon who practices in Elk City, OK, a town of about 12,000 people located about 110 miles west of Oklahoma City. Dr. Buie was raised in the town of Eakly, OK, which had a population of approximately 500 people.

- Peter S. Hedberg, MD, FACS, a general surgeon based in Durant, OK (population 15,000), approaches the topic from a very different point of view. Dr. Hedberg is a native of Boston, MA, and has been situated in a rural area for only about four years.

- James H. Lindsey, MD, FACS, has been carrying on the family tradition of providing care to the people of Pauls Valley, OK, for 37 years. Dr. Lindsey's grandfather and father were both surgeons in the community and Fellows of the College.

Given their very diverse backgrounds, these three surgeons offer unique perspectives on the changing landscape of rural surgery in Oklahoma.

Pictured left, background: Harvey Lindsey, MD, FACS, grandfather of Dr. Jim Lindsey and an early member of the American College of Surgeons, is shown fording a creek on his way to a house call in early-day Pauls Valley. Inset: Dr. Jim Lindsey (right) and Dr. Jeff Garrett check on 99-year-old Maude Fitzgerald, who is recovering from emergency surgery. (Photos courtesy of *SOONER Magazine*, University of Oklahoma Foundation Inc.)

Advancing hospitals

Traditionally, one of the obstacles to offering high-quality surgical care in rural areas has been a lack of well-equipped hospitals. Because they rely on the devices within facilities to perform operations, conduct tests, and provide follow-up care, this deficiency has made rural practice less attractive to surgeons. However, the rural facilities in which Drs. Buie and Hedberg practice have made tremendous efforts to improve technologically and to offer state-of-the-art care.

Dr. Buie practices at the Great Plains Regional Medical Center, a 78-bed hospital that houses a Level III trauma center and serves Elk City, OK, the surrounding small towns, and anyone who gets into a car crash on the nearby interstate. The medical center is the modernized version of what was previously Great Plains Community Hospital, which was started during the Great Depression "as a cooperative under which the local farmers would pay \$10 per year per family in dues," Dr. Buie said. "This money would be pooled to ensure that everyone had access to care, and the physicians all worked for salary."

Once the Depression ended, the cooperative disbanded and Great Plains took on the more typical functions of any small hospital, serving as a non-profit entity and existing "basically for the good of the community," Dr. Buie said. Like other non-profit institutions, Great Plains operated under the supervision of a managing board. In the early 1990s, the board developed a new vision for Great Plains and "started working to build a truly regional medical center," according to Dr. Buie. The board's aim was to attract more surgeons and medical specialists to the area by establishing a fully equipped medical center.

The idea worked to some extent. Today, Great Plains Regional Medical Center has much of the same equipment found in big, metropolitan hospitals. For instance, the hospital offers mobile cardiac catheterization, magnetic resonance imaging (MRI), and spiral CT scans. Additionally, the facility has a fully equipped cancer center, which has attracted a medical oncologist from a nearby city to offer his services to the facility's patients once a month. The addition of the new CT machine, meanwhile, has been "a huge benefit in terms of my ability to provide timely care to trauma pa-



Dr. Hedberg and his family.

tients—to offer care during the ‘Golden Hour’ of trauma,” Dr. Buie added.

Dr. Hedberg also has the luxury of practicing at a good-sized, well-equipped facility—the Medical Center of Southeastern Oklahoma, a 103-bed facility serving a five-county area of 75,000 people. The hospital’s goal is “to bring as much of the big-city hospital to our facility as possible, so that people don’t have to go to Dallas for their care,” Dr. Hedberg said. (Dallas, TX, is located about 100 miles south of Durant.)

Given its ambitious agenda, the hospital recently has added much of the state-of-the-art equipment found in major medical centers, such as MRI machines. Additionally, it has fully updated all the equipment in the intensive care unit and added an outpatient surgical center, an endoscopy center, and a hyperbaric oxygen center for wound healing. As a result, the Medical

Center of Southeastern Oklahoma, like Great Plains to its west, has been able to attract what Dr. Hedberg describes as “a decent mix of specialties.” Indeed, Dr. Hedberg is one of two general surgeons on staff. Also on staff are an orthopaedist, an otolaryngologist, an ophthalmologist, three obstetrician-gynecologists, and one urologist. Great Plains, meanwhile, has one orthopaedic surgeon, one urologist, and one otolaryngologist on staff.

Not all rural medical centers have been able to add the high-tech equipment found in these regional facilities; nor have they expanded their cadre of on-staff specialists. Indeed, Pauls Valley General Hospital, where Dr. Lindsey practices, is perhaps more typical of a true small community hospital. It mostly serves the 7,000 residents of Pauls Valley and neighboring Wynnewood, OK, and has approximately 60 beds. Dr. Lindsey and a doctor of osteopathy (DO) are the only surgical staff based at the facility, although a urologist visits once a week and an ophthalmologist comes to the hospital twice a month.

Unlike the major medical centers described previously in this article, Pauls Valley lacks any MRI machinery, radiotherapy devices, and arteriogram equipment. Nonetheless, Dr. Lindsey can perform endoscopy and laparoscopic procedures. Also, Pauls Valley General houses CAT scan, sonography, fluoroscopy, and mammography devices. The hospital also has a radiologist and pathologist on staff. Dr. Lindsey said that Pauls Valley General has not been compelled to expand and become a regional medical center because it is within 40 miles of the major medical centers in Oklahoma City and at the University of Oklahoma in Norman (OU).

The fact that even small rural hospitals can offer a broader range of services than they did in the past has the obvious benefit of speeding care to critically ill or injured patients. On a perhaps more esoteric level, better access to advanced health care makes receiving care more appealing to the residents of small towns, who tend to be older and less educated than city dwellers.² “Older people, like so many of the residents here, don’t want to leave town, especially when they’re sick,” Dr. Buie said. “Most of the time when I tell them they need an operation, they’ll say, ‘You can do that right here, can’t you doc?’ And now we can.”

Problems persist

Although rural hospitals are expanding their service capabilities and, thereby, improving practice for surgeons and access for patients, rural surgery still has its drawbacks. These disadvantages include reimbursement issues, lack of trained assistants, a continuing lack of specific specialists, and professional isolation. In some case, surgeons are developing methods to work around these barriers, although some of the problems are so inherent in rural practice that they are more difficult to overcome.

Reimbursement

The Federal Office of Rural Health Policy, a division of the U.S. Department of Health and Human Services' Health Resources and Services Administration, reports that nonmetropolitan physicians have annual incomes averaging approximately \$170,000, while physicians in large metropolitan areas average between nearly \$180,000 to \$195,000. Lower incomes are at least partly attributable to the fact that rural physicians derive a larger share of their gross practice revenue from Medicare and Medicaid patients (49%) than their metropolitan counterparts (37%).¹ Dr. Hedberg, for instance, noted that in Durant, where he practices, "we have a lot of poor and elderly people, so about one-third of my patients are in Medicare, one-third are in Medicaid, 25 percent have standard fee-for-service coverage, and the rest are uninsured."

Dr. Buie noted that dependence on public payors affects not only the individual surgeon's bottom line but the capabilities of the hospitals where they practice, as well. "We have the equipment and overhead costs of a big hospital, but we're reimbursed at lower rates because we only have 78 beds," he said.

Exacerbating any frustrations rural physicians may sense because of their lower incomes is the fact that the supply of physicians remains limited. Hence, individuals who practice in nonmetropolitan areas often work harder for less pay. In fact, nonmetropolitan physicians spend as much as 16 percent more time per week in direct patient care and have 38 percent more patient visits per week than physicians in the largest metropolitan areas.² Nonetheless, some



Dr. Buie (right), and James Walker Bonds, MD, FACS, are the two general surgeons on staff at Great Plains Regional Medical Center in Elk City, OK.

rural surgeons are content with their financial situation and time on the job. Dr. Hedberg noted that his income is satisfactory, especially given that the cost of living in small towns is lower.

Limited assistance

Another problem that plagues rural health care centers is a lack of skilled assistants. Dr. Buie said he faces a shortage of registered nurses who are familiar with complex cases and can assist in the operating room. This situation is particularly troublesome given that operating room staff often must act as first assistants because there are no local surgical assistants in Elk City, he said.

"It can be difficult when you're in the middle of an operation and you don't have anyone to turn to for advice and there are no qualified assistants in the room," Dr. Hedberg added. "We often don't have assistants who are capable or willing to assist with a complex case," he said.

Dr. Lindsey, on the other hand, has overcome the lack of skilled surgical assistants in Pauls Valley by turning to the medical students at OU. Pauls Valley General Hospital is one of 26 sites throughout the state that participate in the OU College of



Downtown Elk City, OK, the town in which Dr. Buie practices.

three independent nurse anesthetists.

Dr. Lindsey echoed some of Dr. Hedberg's concerns, adding that "getting highly trained specialists to come into small towns is only going to get harder." Dr. Lindsey also noted that even providing patients with pre- and postoperative services can be troublesome at times, and, as a result, surgeons in these communities must be willing to "do some general practice."

Professional isolation

Not having other surgeons within one's area of expertise or having access to the continuing medical education (CME) programs is another common grievance expressed by surgeons in

Medicine's rural medicine preceptorship program, which Dr. Lindsey's father helped to establish in the 1950s. Every fourth-year medical student must spend a month at a nonmetropolitan state community under the tutelage of an experienced physician. Pauls Valley is reportedly an especially popular site for OU medical students who are interested in surgical careers.³ As a result, Dr. Lindsey usually can count on assistance from one of the medical students for each of the nine months per year that the program is operational.

Continuing shortage of specialists

In addition to a shortage of surgical assistants, surgeons who practice in rural areas lament the paucity of specialists who can handle tough cases despite the more attractive work environments afforded by regional medical centers. Of greatest significance to Dr. Hedberg is that his hospital has no neurosurgeon on staff. While he can handle most of the trauma cases that come into the hospital's Level III trauma center, any head or spinal injuries must be transported to Dallas, TX. Other workforce issues of concern to Dr. Hedberg include the fact that the hospital does not have any nephrologists or infectious disease specialists on staff to help with postoperative care. Additionally, the facility has only one anesthesiologist and

small towns. Indeed, the National Rural Health Association (NRHA) reports that professional isolation is often cited as a reason to leave a rural area.²

Although proud to maintain the legacy of his father and grandfather by practicing in Pauls Valley, Dr. Lindsey said that there have been times when he felt professionally isolated. This perception was particularly strong when he first returned to the town after completing his training at Northwestern University in Chicago, IL. Although he went into practice with his father, he was the only surgeon within several counties performing vascular operations.

"When I first got back, I made a lot of phone calls to professors to get their opinions," he said. "Fortunately, I connected with another vascular surgeon at OU about two or three years later. It's really hard to start practicing, though, if you don't have some consultative backing. It's nice to bounce ideas off somebody."

To overcome his sense of professional isolation, Dr. Hedberg said he relies on the Internet and telemedicine. "I generally turn to the Internet to seek out advice from other surgeons and for research. We don't have a medical library here, so I find Web-based sources very helpful." Additionally, his hospital recently developed teleconferencing

capabilities, which have allowed him to exchange information on wound care and hyperbaric medicine with physicians at all of Oklahoma's medical centers.

Dr. Hedberg is not alone in his use of telecommunications to share and retrieve medical information. The NRHA maintains that "the Internet and teleinformatics can become resources for diminishing isolation" and recommends that the rural health agencies support these systems to increase professional fulfillment.²

Getting help with cases is just one area in which up-to-date communication systems would benefit rural surgeons and other physicians professionally. Surgeons seeking CME credits would find broader computer-based learning opportunities useful.

"We're 150 miles from the University of Oklahoma and 100 miles from Dallas. If I want to get CME, it's not as though I can drive down the road to participate in a course or take time out for a lunchtime lecture. I have to take the whole day off from my practice," Dr. Hedberg said. "It would be nice if there were telemedicine for CME. Paying the tuition and having to take the day off of work gets very expensive."

Telemedicine and teleconferencing most likely will help to fill that gap, Dr. Lindsey said. He said that the preceptor program at OU and 38 years of regular attendance at the College's Clinical Congress have allowed him to stay in touch with the changes in medicine, but he believes telecommunications are going to need to be further developed. "The young medical students who come here through the preceptor program are very dependent on computers to get and exchange information," Dr. Lindsey added. "We had a medical student here last year who was always using the computer to get advice from her colleagues back at the university."

The advantages of rural practice

Despite the professional and financial pitfalls associated with rural practice, the surgeons interviewed for this article truly are pleased with their decision to build a life in the country.

While they may not earn as much as big-city surgeons do, they have fewer hassles with managed care. All three surgeons said that managed care

organizations have not really penetrated their communities, and the only times they have to worry about managed care is when they treat emergency cases involving patients who work in the bigger cities.

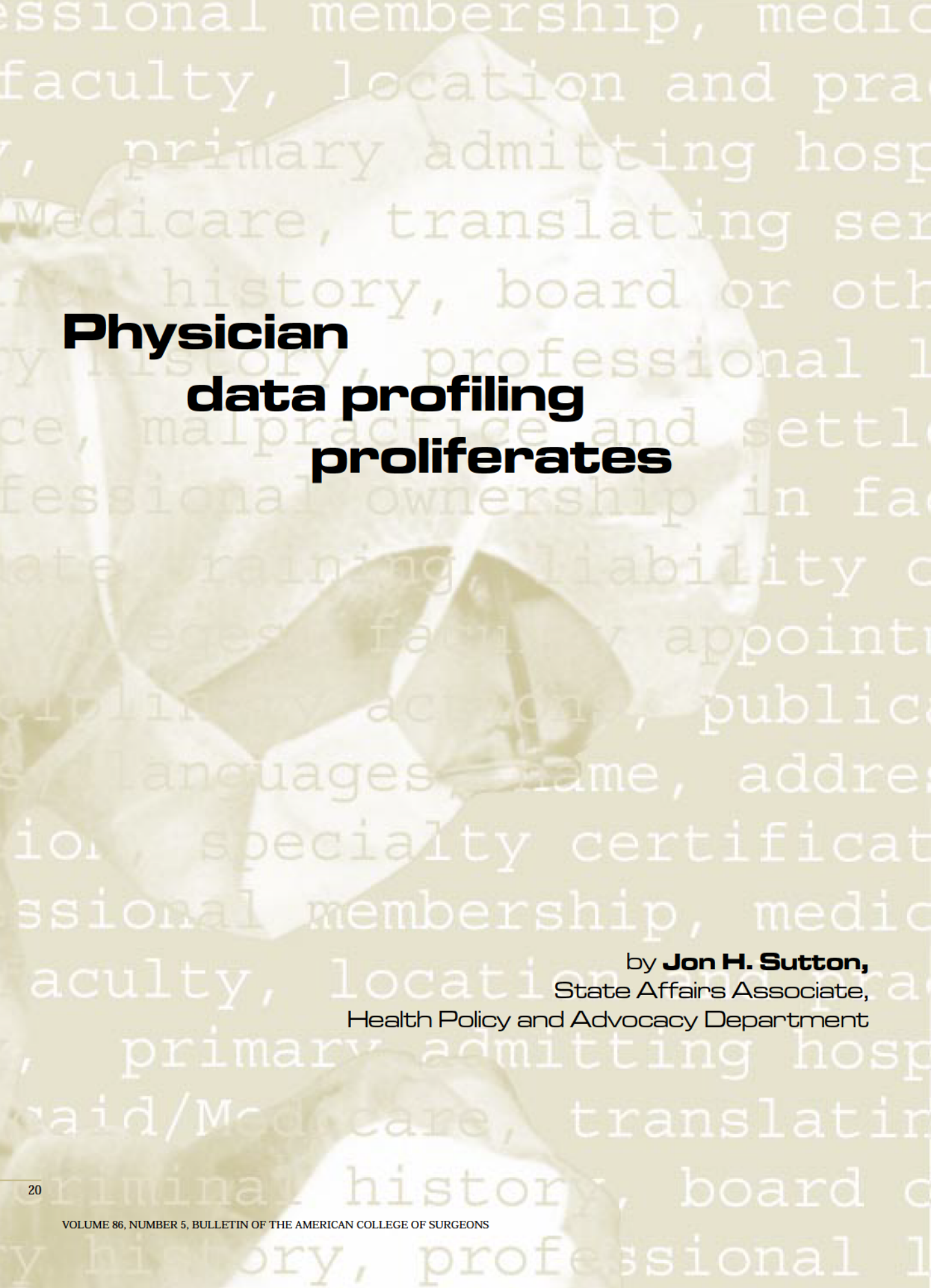
Also, because there are so few surgeons in rural areas, the work is much more varied. "One of the unique things about practicing general surgery in a rural environment is that you can gain nice, broad experience," Dr. Buie, noting that he must be prepared to perform a range of operations, particularly vascular and chest procedures. "It's kind of like being on a basketball team with nobody on the bench," he said. When a patient arrives in the hospital and needs critical care, if one of the specialists isn't available or if no one in that specialty is on staff, the case ultimately "defaults to the general surgeon," Dr. Buie added.

Additionally, rural surgeons like the fact they often know their patients and the other practitioners with whom they work. "I really love the people," Dr. Lindsey said. "There's a lot more personal interaction with the patients and their families. You feel like you really have to do a good job when you know you're probably going to see these people at the grocery store all the time." He said the personal stake in patient care extends to his nurses and, hence, all the practitioners are personally involved in the case. "It becomes more of a team effort, so there's less chance for error," Dr. Lindsey said.

Finally, rural communities often offer a more peaceful lifestyle. "Being a country boy, the lifestyle here suits me fine," Dr. Buie said. "It's a nice place to live. Your neighbors look out for you."

Even big-city folk find the country way of life appealing once they get used to it. "It's a great place to raise kids," Dr. Hedberg said. "The schools are good, and it's very safe." Dr. Hedberg noted that his wife is also from the Boston area, and she was "a little reluctant" to move to Durant when he was offered the opportunity to replace a retiring surgeon. "But now she likes it. She's talking about buying some land and maybe getting a horse and raising some cattle," he said.

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Physician data profiling proliferates

by **Jon H. Sutton,**
State Affairs Associate,
Health Policy and Advocacy Department

For many years, various groups have attempted to expand the availability of physician data to the public. These groups have argued that consumers should have the right to make informed decisions when selecting a physician and, therefore, should have access to such facts as a physician's disciplinary actions, license status, malpractice data, and so on. In addition, the advent of the Internet and the ease with which such information can be made available has driven the trend to transparency with regard to all types of information.

Organized medicine successfully kept a lid on the release of most information until recently, although many states provided basic information (such as disciplinary actions taken against physician licensees) on written or telephone requests from consumers. Then, in 1990, the lid was blown off with the implementation of the National Practitioner Data Bank (NPDB), a federal repository administered by the Department of Health and Human Services that collects information on adverse licensure actions, professional liability payments, clinical privileges actions, and professional society membership actions taken against physicians and dentists. Only selected entities were granted access to the information contained in the NPDB.

In 1996, the Commonwealth of Massachusetts became one of the first states to implement a comprehensive physician profiling program available to consumers through the Internet. Many other states have adopted similar systems. According to an editorial in the January 15, 2001, *USA Today* (p. 12A), physician profiles are available in 30 states, with legislation pending in eight others. In addition, during its final days, the 106th Congress considered a number of bills that would have granted nationwide public access to the information contained in the NPDB; none of the bills passed.

Another factor fueling the debate over the release of physician profiles to the public is patient safety. Since the 1999 release of the Institute of Medicine's report *To Err Is Human: Building a Safer Health System*, many legislators, regulators, and consumer groups have come to see public availability of physician profiles as one aspect of improving patient safety.

This article reviews the status of physician data

profiling requirements in the states and highlights legislative activity taking place in 2001.

Profiling already in place

Most states that offer physician data profiles to the public make this information available through their Web sites, usually the Board of Medicine or Board of Medical Examiners home page. Searching the database generally requires entry of the last and first name of the physician, although a few states also provide a search field for the physician's medical license number. In those cases where multiple physicians have the same name, such as Joseph Jones or William Smith, a drop-down menu shows all of the names, and the correct one can then be selected.

A Web site that serves as a central source for 17 states is the Administrators in Medicine (AIM) DocFinder Web site,¹ found at www.docfinder.org/. This site is maintained by the Association of State Medical Board Executive Directors and provides links to the states' medical board Web sites. DocFinder also helps provide some standards in terms of information formats and types of physician information provided to consumers, most commonly including name and address/location of the physician; license number, status, date issued, and expiration date; medical school and specialty; and disciplinary actions taken against the physician. Beyond these common data fields, information may include CME, whether or not the physician accepts Medicare or Medicaid, telephone/fax numbers, hospitals where the physician may have privileges, and malpractice information.

The 17 states that participate in the DocFinder Web site are **Alabama, Arizona, California, Colorado, Iowa, Kansas, Maine, Maryland, Massachusetts, Minnesota, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, Texas, and Vermont**. In addition, Oklahoma provides a link from the DocFinder Web site to its osteopathic board Web page, and the Washington link connects to the Medical Quality Assurance Commission Web page, which provides a telephone number and address for consumers to call or write to request information on physicians.

States that provide extensive physician profiles but are not part of the DocFinder Web site

include **Florida, Idaho, and Tennessee**. The Florida Department of Health is responsible for that state's physician profile system and has divided the information into the following categories: practitioner information; education and training; professional and postgraduate training; specialty; optional information (professional or community service awards, publications, languages, other affiliations, e-mail address, and other state licensure); financial responsibility (describing level of malpractice coverage); criminal offenses; final disciplinary action within the last 10 years; and liability claims exceeding \$5,000 within the last 10 years (with a general disclaimer statement).²

Idaho provides profiles on a number of health care professionals besides physicians. Information pertaining to physicians is categorized as follows: education; specialty certification(s); special positions (professional membership, medical school faculty, and so on); location and practice history; primary admitting hospital; Medicaid/Medicare; translating services; criminal history; board or other disciplinary history; professional liability insurance; malpractice and settlement history (with footnotes); and professional ownership in facilities, laboratories, and so on.³

In Tennessee, licensed health care providers are required to complete a profile questionnaire. Information in the practitioner profile includes: name, address, and languages; graduate/postgraduate education and training; specialty board certification; faculty appointments; staff privileges; final disciplinary actions; criminal offenses; liability claims (with disclaimer statement); and optional information (publications, awards, and so on).⁴

Meanwhile, two states are in the process of implementing physician data profile systems. **Virginia** passed a law in 1998, and **New York** passed one in 2000. Under the Virginia statute, physician profiles will include information similar to that required by Florida, Idaho, and Tennessee (including malpractice and settlement data). However, Virginia also asks for the names of insurance plans accepted and managed care plans in which the physician participates and requires that any changes in the information contained in the profile be reported to the Board of Medicine within 30 days.⁵

In late 2000, New York's governor signed Senate Bill 8127, the "Patient Health Information and Quality Improvement Act of 2000." This legislation included the provision of physician profiles as part of a larger patient safety initiative (which included hospital and health plan report cards, a study of physician credentialing, creation of a patient safety center, and patient privacy requirement). When implemented, the physician profiles will include, in addition to information common to those in Florida, Idaho, and Tennessee, detailed information on disciplinary actions, malpractice awards and settlements listed in graduated categories as compared with those of other physicians in the same specialty, and criminal convictions.

State legislative activity in 2001

Confirming the continued strong interest in the issue of physician data profiling, a number of state legislatures considered legislation to collect these data and provide them to the public. In some cases, these bills were tied to patient safety or patient safety legislation was introduced as a "vehicle" bill to be amended later in the legislative session, creating a physician data profiling system. Those states with pending legislation include **Arkansas, Georgia, Hawaii, Illinois, Indiana, New Jersey, New Mexico, Ohio, Oregon, Pennsylvania, West Virginia, and Wisconsin**.

Other profiling activity

The Federation of State Medical Boards (FSMB) has collected information on disciplinary actions taken against physicians since 1912 and has developed the All Licensed Physicians Project. This project creates a national database (the Federation Physician Data Center) containing biographical, educational, licensure, and disciplinary information on physicians licensed to practice medicine in the U.S.⁶ This information was made available to the public in January 2001 through the FSMB Web site at a cost of \$9.95 per report.⁷

Profiling experience

During debate over the development of physician profiling systems, numerous pros and cons were discussed by many interested parties. Consumer groups felt that access to physician information, including disciplinary actions and mal-

practice data, was important to help consumers select competent physicians and to protect consumers from “bad” physicians. State government entities, charged with protecting the public health and welfare through licensure and discipline of licensed professionals, felt great pressure to protect the public by providing it with physician information.

Organized medicine, however, felt that providing all types of information, including malpractice settlements and awards, would not be accurate, reliable, or relevant. There was concern that consumers would not understand the complexities of the civil justice system, especially malpractice information, and would think that because a physician had a number of malpractice settlements during a certain time period that he or she was a “bad” or incompetent physician. Concern was also expressed with regard to the reporting of loss or modification of hospital privileges without adequate explanation, as this can be done for administrative or economic credentialing reasons and not necessarily for reasons of physician competence. In addition, it was felt that some information, such as participation in Medicaid, which health plans the physician contracts with, and so on, might not be appropriate because they can change rapidly, making the information in the profile inaccurate. Personal information, such as home address and telephone, should not be included, as this could lead to a dangerous situation for a physician and his or her family.

Open to the public for five years, the Massachusetts Physician Profile System, which includes malpractice information, has the longest track record for this activity. In its first full year of operation (1998), the Massachusetts Board of Registration in Medicine took almost 30,000 telephone calls, received 1.6 million hits on the Web site, and faxed out 58,000 profiles. In 2000, the Web site received about 3 million hits. The executive director of the board also notes that in her opinion, the profiles are “an essential part of the health care environment.”⁸ Although the Massachusetts Medical Society originally had many concerns with the profile system, physicians are now living with it and believe it is working.⁹

An important element of the Massachusetts sys-

tem is the statement included in the section of the physician profile pertaining to malpractice information. This statement, which could be part of any state legislation requiring inclusion of malpractice information in physician profiles, states:

Some studies have shown that there is no significant correlation between malpractice history and a doctor’s competence. At the same time, the board believes that consumers should have access to malpractice information. In these profiles, the board has given you information about both the malpractice history of the physician’s specialty and the physician’s history of payments. The board has placed payment amounts into three categories: below average, average, and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history.

- When considering malpractice data, please keep in mind: Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make individual doctor’s [sic] history more meaningful.

- This report reflects data for the last 10 years of a doctor’s practice. For doctors practicing less than 10 years, the data covers their total years of practice. You should take into account how long the doctor has been in practice when considering malpractice averages.

- The incident causing the malpractice claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to move through the legal system.

- Some doctors work primarily with high-risk patients. These doctors may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk for problems.

- Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that

medical malpractice has occurred.

You may wish to discuss information provided in this report, and malpractice generally, with your doctor. The board can refer you to other articles on this subject.¹⁰

Principles for profiling systems

Discussion of physician profiling systems and the NPDB took place during the AMA's Interim House of Delegates meeting held in December 2000. Delegates accepted the recommendations contained in AMA Board of Trustees Report 31-I-00, which included the policy that the AMA strongly support and actively encourage the provision of accurate and relevant physician-specific information through a system developed and operated by state licensing boards or other appropriate state agencies. Under the adopted recommendations in this report, the AMA believes this information should include felony convictions of physicians reported to state medical boards. In addition, the AMA believes that since serious problems exist in correlating lawsuits with physician competence or negligence and some studies indicate lawsuits seldom correlate with findings of incompetence, only a state licensing board should determine when lawsuit settlements and judgments should result in a disciplinary action, and public disclosure of lawsuit settlements and judgments should only occur in connection with a negative state medical board licensing action.¹¹

ACS views

The College has not adopted a formal position on state profiling systems. At the federal level, however, the College has successfully opposed opening the NPDB to the public, despite the attempts of several lawmakers. The College has argued that Congress created the NPDB for the limited purpose of serving as a flagging mechanism for state licensing boards, health plans, and hospitals. In addition, the College believes that the data contained in the NPDB is incomplete and often inaccurate. A November 2000 report from the General Accounting Office confirmed the College's view of the data. As such, the College firmly believes that this flawed information should not be used to measure physician competence. Finally, the College does not support the inclusion

of residents in the data bank, as they do not have ultimate authority over patient care and are generally named in lawsuits because of trial lawyers' efforts to name all possible defendants.

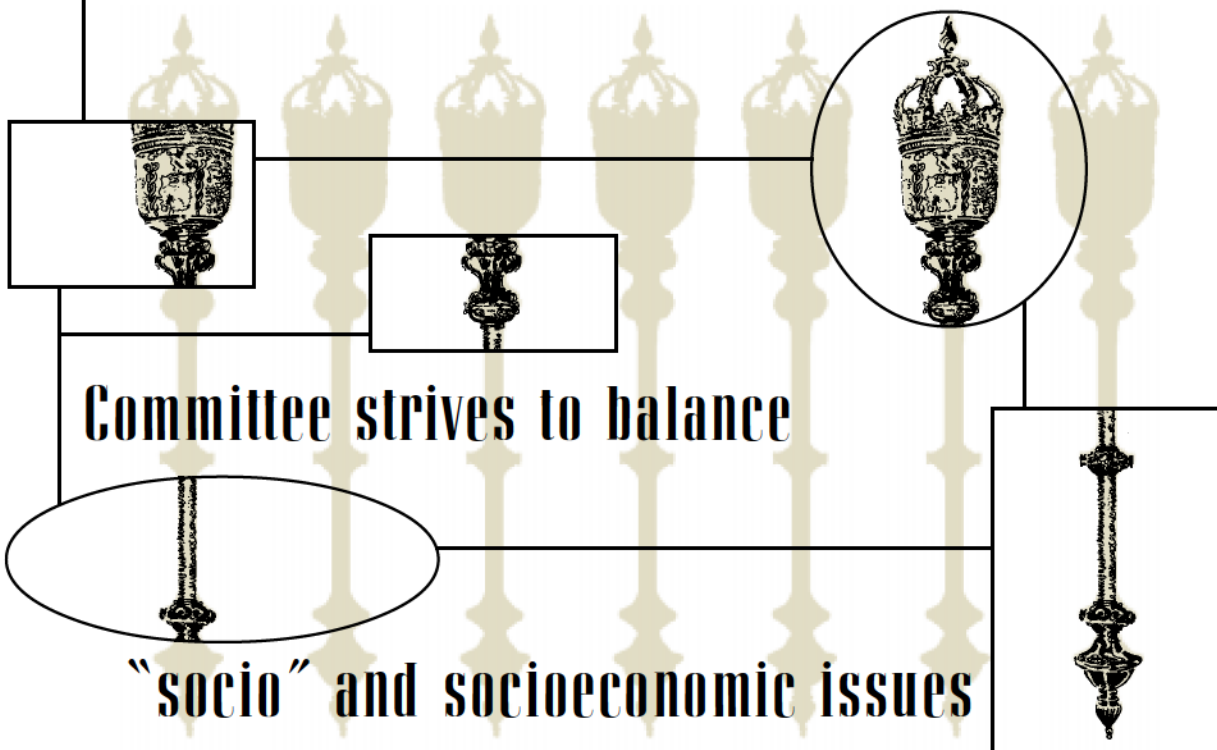
Because the NPDB will remain an important issue for the foreseeable future, the College will continue to advocate on behalf of its Fellows and continue to oppose the opening of the NPDB to the public. □

Author's note

The ACS *Health Policy Brief*, "Physician Data Profiling," provides a more detailed review of physician profiling systems instituted by various state medical licensing boards. This publication is available on the ACS Web site at http://www.facs.org/about_college/acdsept/hpa_dept/hpa_pubs/pubs.html.

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by Andrew L. Warshaw, MD, FACS, Boston, MA

Editor's note: This article is the third in a series highlighting the work of the Board of Governors' (B/G) committees. This article focuses on the B/G Committee on Socioeconomic Issues.

Background

By the early 1980s, it was clear that the government, third-party payors, and other forces would have continually greater influence over surgical practice and patient care. Therefore, at that time, the College more intently began to explore new avenues for working with health care policymakers. To determine which policies were likely to most significantly affect surgeons and their patients, the College turned to the Board of Governors, as they are the direct links between the College's leadership and the Fellows in practice and surgical training centers. The B/G proceeded to establish the Governors' Committee on Socioeconomic Issues (CSI) in 1984, directing this group to study social and political issues and their impact on surgeons.

Like all B/G committees, the CSI has functioned primarily in an advisory capacity—monitoring, studying, and interpreting health policy issues, such as Medicare reimbursement, economic credentialing, alternate health care systems, managed care, and access to specialty care. After assessing these issues, the committee has informed the B/G of emerging concerns and recommended how the College should approach these matters. The B/G then has evaluated the CSI's reasoning and advice and presented proposals to the Board of Regents.

The committee has also been able to work more candidly with the Regents by virtue of the fact that the chair of the CSI has had a seat on the Regents' committees that focus on health policy, including the new Health Policy Steering Committee. Through this position, the chair is able to serve as a more direct conduit between Fellows and Regents.

The CSI, however, has not simply offered counsel on socioeconomic issues; rather, we also have

attempted to develop and propose solutions to some of the problems surgeons bear. For instance, under the leadership of Past-Chair John O. Gage, MD, FACS, the committee worked with the ACS CPT/Relative Work Value (RUC) Committee (now the General Surgery and Coding Committee) to prepare the College's revisions and additions to numerous codes in the Medicare physician fee schedule.

More recently, the committee studied the feasibility of a Surgical Outcomes Data Assessment System (SODAS) in response to third-party payors' efforts to profile surgeons. This effort was led by William S. Tunner, MD, FACS, past-Chair, who provided details on this project in the February 1998 *Bulletin*, p. 40-42, and the February 1999 *Bulletin*, p. 46 and 71.

Current projects

Since October 1999, I have had the privilege of acting as the CSI Chair. One of my goals as Chair has been to get people, both within and outside of the committee, involved and energized. Further, I have sought to take the committee in a direction that answers the appeal from C. James Carrico, MD, FACS, Chair of the Board of Regents, requesting that the College put "the 'socio' back into socioeconomic," (*Bulletin*, December 1999, p.4).

With these aims as our guides, the committee has engineered two major projects. First, we have set out to describe and quantify how American surgeons "give back" to society through volunteer activities outside the scope of their normal practice. Second, we have reconsidered the formation of an ACS political action committee (PAC).

Study on "good samaritans"

Without a doubt, most surgeons contribute daily to the betterment of society by providing care either free of charge or for reduced fees, as well as through teaching, serving on committees within their hospitals or professional institutions, or participating in civic activities. However, the nature, extent, and impact of volunteer activities by surgeons—pro bono activities that fall outside their own economic self-interest—have been largely unknown. To gain a better understanding of the ways in which surgeons

participate in charitable medical activities and how surgeons "give back" to society, the CSI undertook a project in collaboration with the Institute for Health Policy at the Massachusetts General Hospital.

The Giving Back project was initially presented to the Executive Committee of the B/G in February 2000 and received their endorsement. The project design was presented to the Regents in June, who approved and funded phase I of the effort. Subsequently, Thomas R. Russell, MD, FACS, ACS Director, brought the proposal to the meeting of the Surgical Specialty Societies where it was also favorably received. Our purposes, as outlined to the College's leadership, were to set up a database for the ACS, to nurture the growth of participation in volunteerism, to indicate a potential new role for chapters and the ACS in supporting the Fellows, and to enhance the image of surgeons in our public and political relations.

The first phase of the project was completed last year and focused on obtaining qualitative data to determine whether a construct of physician volunteer activities exists, to develop conceptual frameworks, and to make initial comparisons between segments of the membership. At this point, we were interested in the demographic profile of the participants—whether they were rural or urban, private practice or academic, active or retired, young or older, general surgeons or subspecialists, male or female. We also wanted to understand the barriers versus the incentives to participating in volunteer activity.

The initial inquiry was shaped through interviews with 17 members of the CSI and representatives of volunteer organizations. A construct was formed around motivation, enabling factors, and barriers to participation—one of the largest being ignorance of the possibilities and opportunities. Three focus groups, each composed of 16 to 20 randomly selected surgeons, were convened at the 2000 Clinical Congress. The response to the invitation was so uniformly enthusiastic that many individuals had to be turned away.

Indeed, examples of surgeons' charitable efforts poured in to us as we conducted phase I of the project. Among others, we learned of Opera-

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tion Access in California, through which surgeons and hospitals provide free ambulatory surgery on Saturday. We received information about the Face-to-Face program, through which surgeons and other professionals restore the

previously battered faces and self-images of victims of domestic violence. Of course, we also heard many stories about the dedicated efforts of volunteer international disaster response teams, church-sponsored clinics in inner cities

and abroad, and the cardiac surgeon who quietly devotes one day each week to a free primary care clinic.

The outcomes of our inquiries crystallized in a 100-page initial report presented to the College's leadership in January and February of this year. Included in the document are recommendations regarding how the College and the CSI in particular might follow up and take this project to its next stage. These recommendations call for: (1) establishing a clearinghouse for information on volunteer activities; (2) surveying a larger sample of the Fellowship to further map and quantify the extent and nature of their volunteer activities, as well as their interest in learning about such programs; (3) using the Clinical Congress to promote, support, and endorse surgeons' charitable endeavors; (4) identifying and reducing legal and other barriers to volunteer participation; (5) creating a "manual" to illustrate successful volunteer organizations and how to go about creating one; and (6) linking with other medical and surgical organizations and suppliers to provide volunteer surgical care.

The CSI convened during the 2001 Spring Meeting. We have selected action items from the list of recommendations, and created a proposal for the Regents outlining our desired next steps in this project. It is definitely a work in progress.

PAC proposal

In 1995, the Board of Governors rejected a proposal that would have allowed the College to form a PAC, maintaining that the College's political agenda should be carried out locally through the chapters. In voting to oppose the PAC, the Governors were influenced by their desire to function in a clinical and educational context rather than a political one. They were not comfortable paying to gain access or being misconstrued as a trade association.

What has changed in five to six years? For starters, our mission of developing new knowledge, furthering education, and providing the best clinical care is clearly increasingly threatened by current federal funding cuts for medical care and the behavior of managed care organizations. Further, decreased reimbursement to doctors and hospitals and reduced funding for

graduate medical education (GME) threatens the viability of our hospitals now and the strength of the surgical workforce of the near future. The College is in the process of strategic planning, which includes defining its advocacy efforts on behalf of the Fellows and their patients. We believe that we must present a clear national agenda supporting a Patients Bill of Rights, the rights of physicians to negotiate as a group on their own behalf, and the continued funding of GME. To promote our views on these and other issues, we must have a strong, active, coordinated voice.

In reevaluating the issue of an ACS PAC, the committee gathered data through the ACS Washington Office and other medical and surgical organizations that either have a PAC or are considering whether to adopt one. We investigated the specific experiences of several organizations representing surgical and medical subspecialties, such as neurosurgery, cardiology, and orthopaedic surgery. Using this information, we analyzed the pros and cons of PACs, the costs of the programs, the causes and legislators to which they contribute, and their recent budgeted donations. We also studied the tax implications, including the effects on the College's 501(c)3 status and the probable need to create a parallel or affiliated ACS PAC as a 501(c)6 if we choose to proceed. In addition, we examined the experiences of several state medical associations and PACs.

We determined that a PAC could benefit the College on several levels:

- There is a need for organized advocacy for our political agenda, and the Washington Office needs PAC support in this effort.
- Other medical and surgical organizations are doing it. We need to be actively represented or we will lose ground to other more visible players.
- A strong national agenda representing all of surgery will not only have greater clout than individual surgical specialty PACs, but will provide new value to surgical specialists who may query the importance of continuing under the umbrella of ACS membership.
- There is now a strong desire among the Governors for the formation of a PAC. This feeling crosses the boundaries between private practice and academic surgeons. (Two-thirds of the

CSI characterizes itself as private practice and one-third as academic practice.)

We also discovered that a PAC could have some negative effects on the College, including:

- The ACS would probably need to change its tax status or create an affiliated 501(c)6.
- A PAC might appear to signal a change in ACS philosophy and self-image.
- A PAC would create the need for a selective unified national agenda that might conflict with the needs of local or specialty society agendas and, therefore, make it difficult to speak with unanimity on some issues.
- A PAC makes choices and creates both friends and enemies. Who will make these choices, and how will they be vetted?
- A PAC is expensive. To be a "player," the yearly expenditures may exceed \$750,000 (although this sum averages out to only about \$12 per Fellow per year).
- There are many other PACs. Would ours have an impact?

After considering and debating the evidence, the committee, with a measure of regret that the times and environment brought us to the point where we need to take this action but with a strong sense of purpose, voted unanimously to propose the following motion to the Governors:

The Board of Governors recognizes the merits and importance of political activism to promote the ACS goals of developing new knowledge, education, and the finest care of surgical patients. We therefore strongly urge the Board of Regents to consider the formation of an ACS PAC and to educate the Fellowship in its purpose and to participate in this venture.

The B/G has reviewed and approved this statement. The Executive Committee of the Regents has passed it on to the Regental Health Policy Steering Committee for their consideration.

Future activities

The committee plans to see both of the projects through to much more mature states in the future. Additionally, we are preparing to launch a program that will help to educate Fellows about the Emergency Medical Treatment and Labor Act (EMTALA), a 1985 anti-dumping law. We

have started by studying implications of the act for Fellows and their awareness of those implications. The big challenge, however, is to define an effective course of action to reduce the adverse effects of EMTALA on surgeons while promoting its desired benefits for patients.

Of course, there may be socioeconomic items and problems of greater or equal concern to Fellows. If there are appropriate health policy issues that you believe the CSI should be studying or working to correct, please contact one of the members of the committee (see roster, p. 27) or me. Our role is to serve you as liaisons to the College's leadership on socioeconomic issues. 

Dr. Warsaw is W. Gerald Austen Professor of Surgery, Harvard Medical School, and surgeon-in-chief, Massachusetts General Hospital, Boston. He is also Chair of the B/G Committee on Socioeconomic Issues.



Guidelines for collaboration of industry and surgical organizations in support of research and continuing education

Encouraged by the College's Advisory Council for General Surgery, these guidelines were developed by the College's Committee on Ethics. They were approved by the Board of Regents at its meeting on October 20-22, 2000.

Collaboration between the medical industry and surgeons and surgical organizations has benefitted health care delivery in North America for years. Financial support from industry has enhanced surgical research and the continuing medical education (CME) of surgeons. However, the primary objective of professional interactions between surgeons or surgical organizations and industry should be the improvement of patient care. It is the responsibility of surgeons to ensure that this care is not inappropriately affected by collaboration with industry. Surgical organizations need to organize CME programs of the highest quality for their members, while maintaining costs at a fiscally responsible and reasonable level. These guidelines for industry support seek to maximize corporate participation in CME programs while maintaining the autonomy and impartiality of individual surgeons and surgical organizations. They are based on the principles of: (1) openness; (2) quality of teaching and research as determined by experts; (3) freedom from conflict of interest; and (4) appropriate recognition for industry support.

I. General guidelines: Meetings

A. Surgical organizations should have the ultimate responsibility for the planning and development of CME programs. Industry supporters of CME programs should not influence the planning, content, or implementation of an organization's CME program.

B. Industry supporters may not organize any functions involving attendees at a surgical organization's CME program that conflict with scientific sessions or social events. Industry exhibits should enhance the scientific activities of the CME program and not interfere with the scientific program.

C. Industry supporters may not use the surgical organization's name, logo, or seal in conjunction with advertising or promotion without written permission of the organization.

D. Written or recorded details of the scientific program may not be reproduced without the written consent of the surgical organization.

E. Industry sponsors may not offer direct payment to CME program organizers, participants, or attendees to cover travel, accommodations, or honoraria, nor may such individuals accept payments if offered. Support of CME programs shall be accepted only as unrestricted grants or as exhibitor registration fees.

F. No industry promotional materials should be displayed or distributed in the same room during scientific

presentations of single session meetings. In larger meetings with multiple simultaneous sessions, the access to promotional materials shall be controlled by the surgical organization in order to avoid any appearance of a direct connection between the distribution of promotional materials and the scientific presentation.

G. Representatives of industry sponsors may not engage in sales or promotional activities during scientific sessions, social events, or business meetings.

H. Industry support of the meetings through educational grants or exhibitor fees may be acknowledged on promotional materials and/or in the agenda of the CME program. Scientific session moderators may recognize support during the announcements of the meeting.

I. Program committees may not be in a position of conflict of interest by virtue of an undisclosed relationship with industrial companies that fund CME activities or surgical research activities.

J. Presenters' lectures or posters shall disclose, as part of their presentation, any industry support related to the work being presented.

II. General guidelines: Research/grants/fellowship awards

A. Scholarships or other funds to permit medical students, residents, or fellows to attend educational events shall be permissible as long as the selection of participants for these funds is made by their academic institutions or by a surgical organization.

B. Selection of research grants and/or awarding of fellowships supported by industry shall be made by surgical organizations free of any influence from industry.

C. Industry support of research may be recognized in the minutes of business meetings. However, industry representatives may not occupy prominent positions at business meetings, scientific sessions, or social events.

III. Management of funds from industrial sponsors

A. Decisions regarding funding arrangements for CME programs should be the responsibility of

the surgical organization's board or executive committee (or equivalent). Funds from industrial supporters shall be in the form of an unrestricted educational grant made payable to the surgical organization, or in the form of a CME program exhibitor registration fee. The terms, conditions, and purposes of such grants and funds shall be documented by a signed agreement between the industry supporter and the surgical organization. No funds from an industrial source should be paid to the members of the organization's board or executive committee, or others involved in planning CME meetings.

B. Industrial support shall be disclosed in printed announcements and programs and in all manuscripts published of work supported with industrial funding; however, reference may not be made to specific products. 

These guidelines concerning corporate participation of CME programs and research have been compiled based on the published guidelines of the American College of Surgeons, the American Medical Association, the Accreditation Council for Continuing Medical Education, the Canadian Medical Association, and the Royal College of Physicians and Surgeons of Canada.

Socioeconomic tips of the month

Correct use of modifier -59

Much uncertainty surrounds modifier -59 and its correct use. This month's socioeconomic tip is intended to allay some of this confusion so that surgeons properly code with modifier -59. Additionally, as requested by a reader, the distinction between modifiers -59 and -51 will be addressed.

History

Modifier -59, distinct procedural service, is intended to describe instances in which physicians provide separate and distinct multiple services to a patient on a single date of service. Modifier -59 also may be appended to codes designated as "separate procedure" when carried out independently or considered to be unrelated or distinct from other procedures or services provided at the same time.

Modifier language

Distinct procedural service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier -59 identifies procedures/services that are not normally reported together but are appropriate under the circumstances. Such circumstances may be a different session or patient encounter, different procedure or operation, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier -59. Only if no more descriptive modifier is available, and the use of modifier -59 best explains the circumstances, should modifier -59 be used. The complete modifier -59 language is listed in Appendix A of *CPT* 2001. Examples of uses of modifier -59 are:

- Different session or patient encounter
- Different procedure or surgery
- Different site or organ system

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- Separate incision/excision
- Separate lesion
- Separate injury

As stated previously, modifier -59 may be appended to codes that are designated as "separate procedure," when the "separate procedure" code is carried out independently or is considered unrelated or distinct from other procedures/services provided at the time. The code designated as "separate procedure" may be reported by itself or in addition to other procedures/services by appending modifier -59.

Appending modifier -59 indicates that the procedure is not considered to be a component of another procedure, but is a distinct independent procedure. However, it is important to remember that if a "separate procedure" code is considered an integral component of a larger procedure, then it should not be reported separately.

Examples of modifier -59

- If a colonoscopy is performed with biopsy of one lesion (45380) and removal of a second separate lesion (45384), then both codes would be reported. In this instance, modifier -59 would be appended to code 45384 to indicate that there is a separate incision/excision and different lesion. However, if a colonoscopy is performed with biopsy and removal of the same lesion, then only the removal of lesion is reported (45384). It is inappropriate to report a biopsy of lesion code and excision code when the same lesion is removed.

- If the physician excises two cysts (19120) through two separate incisions in the breast, then code 19120 would be reported twice. However, if both cysts were removed through the same incision, then code 19120 would be reported only once, as the code language reads, "one or more lesions." In this instance, as two separate incisions were made in the breast to remove two cysts, code 19120 would be reported twice. When reporting this service, it is important to recognize that some third-party payors may require you to report code 19120 one time and place a "2" in the units box of the Medicare 1500 form. However, if your third-party payor requires that the code be reported on two

lines, then modifier -59 would be appended to the second use of 19120 to indicate that a separate incision/excision was performed to remove the cysts. Appending modifier -59 helps clarify that the physician performed a distinct procedural service.

- A surgeon examines the neck for primary hyperparathyroidism while exploring the parathyroids (60500), and encounters a thyroid nodule that is suspicious for malignancy. Due to the encounter of the unsuspected thyroid nodule, a thyroid lobectomy and isthmusectomy is performed (60220). Both procedures were performed by the same surgeon, at the same operative session, and through the same incision; therefore modifier -51 would be appended to code 60220 to indicate multiple procedures. However, as there were distinct disease processes, modifier -59 should also be appended to code 60220 to indicate a distinct procedural service was performed.

- A surgeon performs a cholecystectomy for cholelithiasis and splenectomy for splenic infarct on a patient with sickle cell anemia. CPT code 38100 would be reported for the splenectomy and code 47600 would be reported for the cholecystectomy. As code 38100 is a "separate procedure," modifier -59 should be appended to indicate that the separate procedure is not considered to be a component of another procedure (the cholecystectomy), but is a distinct independent procedure.

When to use -59 versus -51

Modifier -51 describes multiple procedures, other than evaluation and management services, performed during the same session by the same surgeon. Modifier -51 should not be appended to codes designated as "add-on" codes, as they are exempt from its use. Appendix E of the 2001 *CPT* manual lists all of the add-on codes. Appendix F identifies CPT codes exempt from the use of modifier -51, but that have not been designated as add-on codes. Following are four instances in which modifier -51 may be appended:

- Multiple medical procedures performed by the same provider during the same session.
- Multiple related operative procedures performed by the same provider during the same session.
- Operative procedures performed in combination by the same provider during the same session; which could done by the same or separate incision

or involving the same or different anatomy.

- Combination of medical and operative procedures performed by the same provider during the same session.

It is important to recognize that modifier -59 language states that when another already established modifier is appropriate, it should be used rather than modifier -59. Only if no more descriptive modifier is available, and the use of modifier -59 best explains the circumstances, should modifier -59 be used. Hopefully, using these guidelines and examples will help clarify when to use modifier -59 versus -51. As always, you should familiarize yourself with third-party payor reimbursement policies, as some third-party payors may not recognize some CPT modifiers.

Important CPT errata

For 2001, CPT added a new code, 19295, which describes percutaneous image-guided placement of a metallic localization clip during breast biopsy. The parenthetical note following this code says to use code 19295 in conjunction with 19102. Although not specifically included in this parenthetical note, code 19103 may also be reported in addition to code 19295. The *CPT Assistant* included this statement in the January 2001 issue, with a note indicating that the CPT editorial panel is currently reviewing the revision of this cross-reference for CPT 2002. 

The American College of Surgeons would like to thank Karen R. Borman, MD, FACS, vice-chair of the CPT editorial panel, and John T. Preskitt, MD, FACS, ACS CPT Advisor, for their review and comments.

This column responds to questions from the Fellows and their staffs, and provides useful tips for surgical practices. Developed by the College staff and consultants, this information will be accessible on our Web site for easy retrieval and future access. If there are topics that you would like to see addressed in future columns, please contact the Health Policy and Advocacy Department, tel. 202/337-2701; fax 202/337-4271; or e-mail HealthPolicyAdvocacy@facs.org.

New members join ACS executive staff

ACS Executive Director Thomas R. Russell, MD, FACS, recently appointed two new members to the executive staff of the College. Cynthia A. Brown became Director of the Health Policy and Advocacy Department, and Jean DeYoung became Director of the Human Resources Department.

In announcing Ms. Brown's appointment, Dr. Russell said, "Cindy is well known by health staffers on Capitol Hill, by the national medical community in Washington, DC, and Chicago, IL, by the College's leaders, and by chapters and individual Fellows. Cindy's long association with the College and experience in the Washington arena make her eminently qualified to assume this new leadership role with the College."

Ms. Brown came to the College in 1987 as a Washington Associate. In that capacity she was responsible for monitoring and analyzing key issues, including physician reimbursement, trauma system development, graduate medical education, professional liability, and biomedical research. She also served as the Administrator of the Metropolitan Washington Chapter of the College. In 1990

she was promoted to Manager of the Washington Office and she has served as Associate Director of the Health Policy and Advocacy Department since last year.

Prior to joining the College staff, Cindy held positions with the American Tort Reform Association, the Blue Cross and Blue Shield Association, and the House Energy and Commerce Subcommittee on Health and Environment.

Ms. DeYoung came to the College in 1983. She has been serving as a Human Resources Associate since 1990, utilizing her skills in recruiting, interviewing, and screening of candidates for positions in the organization.

Prior to joining the College staff, Jean held human resource positions with Cook Associates and the Illinois Criminal Justice Commission, both located in Chicago, IL.

Regarding Ms. DeYoung's new position, Dr. Russell noted, "As a human resources generalist, Jean is experienced in matters related to budgeting and cost controls, unemployment claims, employment laws, employee relations, and career development. I am very pleased to announce her appointment."



Ms. Brown



Ms. DeYoung

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Tracing the “roots of philanthropy” at the chapter level

by Lynn H. Harrison, Jr., MD, FACS, New Orleans, LA

As chronicled in an article by Robert E. Berry, MD, FACS (*Bulletin*, October 2000, p. 15), “the roots of philanthropy run deep in the College’s history.” Repeatedly, individual Fellows have helped the College to create a pool of funds for special and ongoing projects, beginning in June 1914, when 1,000 Fellows each pledged \$500 at the suggestion of George Crile, MD, FACS, to establish an endowment fund. Soon after, in 1919, Fellows contributed to the purchase of the College’s original headquarters—the Nickerson Mansion in Chicago, IL. Additionally, Fellows generously helped to raise a total of \$500,000 toward the establishment of the Murphy Memorial Auditorium and, in 1950, \$19,782 toward the costs of the College’s hospital standardization program.

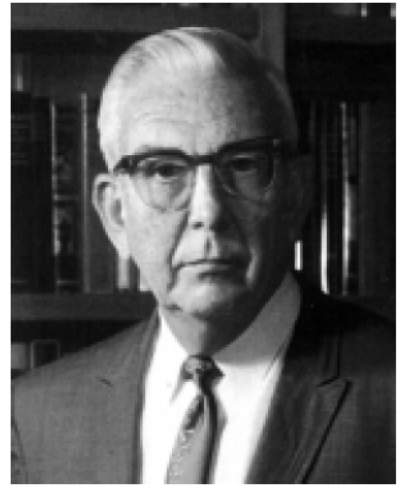
Contributions from major drug and device companies also have enabled the College to carry out its missions of providing continuing education opportunities to surgeons and of awarding scholarships and grants to promising residents. This tradition began in 1944, when Johnson & Johnson gave \$25,000 to the College to support training for surgeons during the few World War II years when the Clinical Congress was suspended. Limited corporate sponsorship continues today, with ongoing research scholarship funding from

Ethicon and recent funding for production of the CD-ROM of the *Owen H. Wangenstein Surgical Forum* provided by Ortho-McNeil. In addition, Wyeth-Ayerst significantly supports the College’s scholarship program.

Also invaluable to the College’s Development Program are the contributions of the individual chapters. Indeed, all of the individual and corporate donations discussed up to this point responded to a specific need. It wasn’t until the Louisiana Chapter started the Fellows Endowment Fund that a perpetual fund came to exist within the College.

Dr. Holcombe and the fund

The seed for the Fellows Endowment Fund was planted during the 1971 Clinical Congress, when a review of the College’s financial status was presented to the College’s Board of Governors. In the audience was R. Gordon Holcombe, Jr., MD, FACS, a Governor-at-Large from Louisiana, who noted that despite a large annual budget supporting a broad spectrum of programs in surgical education and research, the College enjoyed minimal endowment support. The overwhelming majority of funds available to the College for its programs were generated through annual dues paid by Fellows. After ruminating on that fact and the inevitability of



Dr. Holcombe

progressive dues increases simply to maintain the status quo, Dr. Holcombe came up with the idea of the Fellows Endowment Fund.

He specifically envisioned a capital fund supported on a purely voluntary basis by the Fellowship for use in support of the College’s programs as determined by the Board of Regents. The purpose of the fund would be to ensure that the goals and activities of the College could continue perpetually without the need for dues increases that over time might place membership beyond the financial reach of young surgeons.

In November 1971, Dr. Hol-

combe wrote to C. Rollins Hanlon, MD, FACS, the Director of the College, outlining his proposal for the fund. It was Dr. Holcombe's vision that the individual College chapters would solicit voluntary contributions from their memberships and these funds would then be forwarded to the College for investment and distribution. The corpus of the fund would only be spent in the event of dire necessity, but the interest would be available for use in whatever capacity the Board of Regents deemed appropriate.

Dr. Holcombe's concept was endorsed by several leaders of the College and Dr. Hanlon presented the idea to the Board of Regents. The Regents agreed to start the Fellows Endowment Fund, following the plan outlined by Dr. Holcombe in terms of collection and remissions: it would be voluntary, it would be disassociated from College and chapter dues, and it would be maintained separately from the general endowment fund of the College.

Satisfied with the response from the Regents and eager that Louisiana take a firm lead in this effort, Dr. Holcombe presented his plan to the Louisiana Chapter. The chapter accepted his proposal and made the initial contribution to the fund in honor of four Louisiana surgeons who had served as Presidents of the ACS: Rudolph Matas, C. Jeff Miller, Alton Ochsner, and Howard Mahorner.

It is clear from Dr. Holcombe's correspondence with a wide number of surgeons in and out of the administrative hierarchy of the College that his concept

from the beginning was that other chapters would follow suit. Word of the Louisiana initiative spread quickly, and other chapters did, in fact, soon follow Louisiana's lead, the first among them being the Nebraska, Missouri, Michigan, and Texas Chapters.

Dr. Holcombe concisely stated the need, mechanism, and the philosophy behind the Fellows Endowment Fund in a September 9, 1974, letter to Frank H. Kidd, Jr., MD, FACS, encouraging the Texas Chapter's involvement in the fund. He explained that the fund was necessary for four reasons:

- (1) the College's programs are almost totally dependent on financing from Fellowship dues; (2) the general endowment fund for an organization of 59 years seems alarmingly small (in the neighborhood of \$2 million), particularly when one considers the great importance of the American College of Surgeons' exemplary role to date in the furtherance of American surgery; (3) special studies and programs requiring large sums depend on the development of funding from outside sources; (4) large bequeaths and sizable contributions to the general endowment fund had not been commonplace in the past and perhaps would be even less likely in the future.

With these facts in mind, plus a mental image of worthy programs of which the College might be capable if it were unhampered by financial limitations, I conceived the rather obvious and simple

idea that over 30,000 giving annual small donations to a nonexpendable capital fund, from which only the interest each year would become available for appropriate uses decided upon by the Regents, could achieve the desired end. The idea that whatever each of us put into this would remain there in perpetuity to grow with each successive generation of Fellows contributing seemed altogether appealing, as though each of us would be helping long after he was dead and gone.

Dr. Holcombe's legacy does live on. In recognition of the significant impact that Dr. Holcombe had on the College by initiating the Fellows Endowment Fund, along with his service to the Louisiana Chapter, to surgical education, and to his community, Dr. Holcombe received the College's Distinguished Service Award (DSA) in 1980. The DSA is the highest honor accorded by the American College of Surgeons.

Chapter involvement today

In 1987, the College established through its Organization Department a Committee on Development, created specifically to coordinate and channel philanthropic support for the College, especially the financial resources springing from the Fellows Endowment Fund. Its first Chair was Robert E. Hermann, MD, FACS, of Cleveland, OH, and in its first year of operation, a total of \$267,408 was received.

The following year, the Fellows Leadership Society was formed

to acknowledge extraordinary contributions by Fellows, their families, and friends. Chapter contributors to the Development Program also qualify for membership in the Fellows Leadership Society. Chapters and individuals are accepted into the Fellows Leadership Society if they contribute \$1,000 in a single year. Philanthropists who contribute \$10,000 or more in total are named Life Members of the Fellows Leadership Society.

As of March 2001, a total of 61 chapters had made contributions at some level to the Fellows

Endowment Fund, resulting in total chapter donations of more than \$678,960. The Louisiana Chapter remains the leader, having contributed \$85,835. The current Fellows Endowment Fund exceeds \$2.3 million, and its reserves are used to fund scholarship programs.

One of the priorities of the Committee on Development is to reach out to the chapters more effectively. The Development Program is currently developing new materials on philanthropic opportunities at the College for display at ACS chapter meet-

ings. This initiative will begin this summer.

For more information about chapter contributions to the College's philanthropic opportunities, contact the ACS Development Program office by letter at 633 N. Saint Clair St., Chicago, IL 60611, by e-mail at fholtzrichter@facs.org, or by phone at 312/202-5376.

Dr. Harrison is professor of surgery and chief, section of cardiothoracic surgery, Louisiana State University Medical Center, New Orleans.

College materials prepare surgeons for defense trial

The Regental Committee on Patient Safety and Professional Liability has prepared a packet of information for Fellows of the College who are involved in a medical malpractice suit or have had an adverse patient event that has the potential for medical liability.

Fellows of the College continue to request the Professional Liability Information Packet, which has now been updated to include materials from the second edition of *Professional Liability/Risk Management: A Manual for Surgeons*. It is hoped that the materials in this packet will continue to be helpful to surgeons who anticipate a suit or who are in the process of preparing for trial.

The packet includes the following:

- Chapter V: Claims Management, from *Professional Liability/Risk Management: A Manual for Surgeons*. The chapter includes sections on the surgeon-attorney relationship, the deposition, the trial, the settlement, and the process of protecting one's assets.

- The ACS "Statement on the physician expert witness," revised June 2000.

- "The expert medical witness: Concerns, limits, and remedies," by Frank C. Spencer, MD, FACS, former Chair of the Board of Regents' Committee on Patient Safety and Professional Liability, and Karen S. Guice, MD, FACS. *Bull Am Coll Surg*, 85(6):22-23, 2000.

- "The psychological trauma of being sued," by Sara C. Charles, MD.

- "A case for the physician defendant at plaintiff's expert witness deposition," by Richard Reiling, MD, FACS, and Gregory C. Gibson, JD. *Bull Am Coll Surg*, 84(11):18-22, 1999.

- IDEX—clearinghouse/database for information regarding testimony by plaintiff's expert witnesses.

Fellows may obtain a copy of the Professional Liability Information Packet free of charge by contacting Ruth Shea, Patient Safety and Professional Liability Program, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211; tel. 312/202-5413, fax 312/202-5021, or e-mail rshea@facs.org.



Letters...

The following comments were received via e-mail regarding the "From my perspective" column written by Thomas R. Russell, MD, FACS, and published in the March 2001 issue of the Bulletin. The column focused on the residency review committee (RRC) for dermatology seeking to establish a subspecialty in dermatological surgery (see www.facs.org/fellows_info/bulletin/mar01bullet.html).

I was reading your thoughts about the RRC of dermatology seeking to establish a subspecialty in dermatological surgery, and I urge you to hold your ground. In your section on "Appropriate training for surgery," you succinctly state that there is a lot more to surgery than the technical aspects, and you speak about the fact that the ultimate criteria used to evaluate surgeons is their use of judgment. This is an extremely important point, and you need to stress this in your presentations. When I was a resident and a more junior surgeon, I felt this judgment issue was about difficult intraoperative decision making only. As I have matured I've noticed what separates the "men from the boys" is the maturity of knowing when not to operate, how to take care of a patient without operating, how to do no harm.

It is a huge responsibility and privilege to have a patient let you perform an operation. It's an extremely serious obligation and relationship that is not fostered in a medical residency. It is this responsibility that keeps the surgeon up all night in the ICU with a patient and part of the reason we have "turf wars" with intensivists and pulmonologists. It's a dedication issue that starts with the initial history-taking and lasts until that patient is safely through their operation. The American College of Surgeons is a society fostering the ultimate in professionalism and class. It sets the standards and holds the bar

high. I propose that if there continues to be pressure from the RRC, then the "dermatological surgeons" need to be fully trained general surgeons who then go on to specialize in skin-type procedures as you've described, not medical residents learning some techniques; that only denigrates us.

I urge you to hold your ground, for the patients' sake as well as the rest of the surgical community, as we will be the ones to clean up the mistakes and the errors of judgment that will occur. Thank you for your time and interest.

**Denise M. Fraser,
MD, FACS**

I surely appreciate your editorial in the March issue of the *Bulletin*. Personally, I believe that "surgeon" is a revered title and should not be demeaned by the process that the dermatologists are seeking. I continue to be shocked from time to time at some of the surgical procedures that they do undertake. I appreciate your fighting for this issue.

David Vanderpool, MD, FACS

I could not agree more with your comments in the *Bulletin*. No one-year fellowship can impart the judgment and insight necessary to be a safe surgeon. As a double-boarded diplomate, I have felt growing concern and frustration in regard to the issue of scope of practice and board certification. In my local market, at least one dermatologist has been doing liposuction for a long period of time and oral surgeons are actively pursuing privileges for rhytidectomy and other cosmetic venues. Who will pick up the pieces if and when there is a complication remains to be seen. The fellowship issue is definitely worth fighting for.

Andrew Mandery, MD, FACS

I agree fully with your opinion about dermatologic surgery as expressed in the *Bulletin*. I did a year

of surgery, a year of neurology, five years of neurosurgery, and a one-year fellowship in vascular neurosurgery. Most of my colleagues in neurosurgery and other specialties spent a similar amount of time in training. One cannot learn to be a surgeon in one year.

Stuart Lee, MD, FACS

I read with interest your op-ed piece in the March issue of the *Bulletin*. Here in New Jersey we actually have a dermatologist locally in Morristown who regularly performs plastic surgical procedures in his office, within a large practice. He does hair transplants, excisions of bald areas of the scalp with flap closures, and so forth. I think these operations can be done because the head and neck areas are so naturally resistant to infection.

Last year this individual applied for surgical inpatient privileges in the division of plastic surgery at our hospital. He was turned down and didn't press the matter.

I support your position on the part of the ACS, and indeed the public, to preserve the essential foundations of what constitutes proper training and functioning as a surgeon—one's judgment, not one's technique.

Mark W. Moritz, MD, FACS

I agree wholeheartedly with all the points you made in your editorial. I don't know how things are in California these days, but in Florida they are awful. We have family practitioners and ophthalmologists doing full body liposuction, anesthesiologists doing breast augmentation, and oral surgeons, dermatologists, and ophthalmologists doing facelifts—all quite legally! It seems everyone wants to be a plastic surgeon. I can understand that, since it is a wonderful and very gratifying profession and the "cash on the barrelhead" nature of cosmetic surgery is certainly attractive in this day of declining re-

LETTERS, continued

imbursement from third-party insurers. What I can't understand is the pell-mell rush to discard our long-established residency training system in order to allow a few individuals to circumvent the formal training process and call themselves plastic surgeons.

I recently chaired an ad hoc committee at one of our local hospitals to determine how to handle the request for cosmetic facial surgery privileges by an ophthalmologist. This fellow has undergone literally years of cosmetic preceptorships and fellowships, none of them sanctioned, has published extensively (his CV is several pages longer than mine!), and extensive operative experience. The question came down to whether we throw out the accepted residency tracts for facial plastic surgery (through plastic surgery or ENT residency) for a single individual, no matter how qualified he might seem to be, or deny him privileges. Others on the committee were an ENT specialist with fellowship training in facial plastics and an oculoplastic surgeon. We were at our wits' end as to how to resolve this dilemma. Ultimately, we pushed to maintain the status quo, reasoning that as a small community hospital we did not feel it was our place to alter how surgeons have been trained for decades. The fellow, to our great relief, found our small community too limiting and moved on to greener pastures.

I see a steady, and not altogether slow, erosion in the way surgeons are being trained. I applaud your efforts and thank you for the very timely editorial.

**Richard T. Bosshardt,
MD, FACS**

Thank you for your editorial on the proposed dermatologic surgery fellowship program. Your comments on surgical judgment are very apropos. I have seen this in my practice—a dermatologist may

know how to do a rotation flap, and so forth, but then use it in an inappropriate way—for example, distorting the normal anatomy. My experience here in Tallahassee is that the dermatologists have taken primary control of skin cancer through their use (or overuse) of Mohs' surgery. I can only imagine that this is placing a rather large drain on Medicare funding. I do not do liposuction in my practice, but from what I have seen, a dermatologic surgery fellowship will be the beginning of an aggressive expansion of their claimed areas of expertise.

**James Randall Jordan,
MD, FACS**

My issue of the *Bulletin* arrived today and I read your commentary with great interest and concern. I am in complete agreement with the College's position regarding the request by the residency review committee for dermatology.

In my 15 years of practice, I have become a strong believer in the importance of thorough and fastidious training for surgeons. Not only did I do eight years of residency, but I am one of the few plastic surgeons in the country that has recertified with the American Board of Surgery. Even with all this, I am continually learning and am humbled by the knowledge that is needed to truly be an effective and safe "surgeon."

The closest that dermatologists have come to aggressive surgical techniques, aside from the high-profile liposuction deaths, has been surgery from the Mohs' technique of removing skin cancers. With a fellowship (accreditation?) in Mohs' surgery, some dermatologists have removed huge amounts of soft tissue in an outpatient setting, often to the patient's detriment. As you rightly point out, none of this is peer reviewed because it occurs outside the hospital or outpatient surgery-center setting.

I will continue to vigorously educate the public about what it means to be a qualified "surgeon." Thank you for your excellent article.

Leland Deane, MD, FACS

I was delighted to read that the College has taken a strong position and is actively attempting to discourage the Accreditation Council for Graduate Medical Education from approving the proposed dermatological surgical fellowship. I wholeheartedly agree that this is an issue worth fighting for and encourage you to continue with your tough stand on this vital issue.

Foad Nahai, MD, FACS

I read with interest your comments on (this) issue, and as a surgical specialty residency program director, I am fully supportive of the position which the College has taken on this matter. Every surgeon knows there are no short cuts on the road to competence in our business. I am very pleased to see the College take a strong position on this matter, which is clearly in the public interest, and I sincerely hope your view prevails.

**Michael Coburn,
MD, FACS**

In response to your editorial, "From my perspective" (March 2001), on the subject of a subspecialty in dermatological surgery, let me address the issue as one who is board certified in dermatology and otolaryngology and a Fellow of the College.

In reality the subspecialty of dermatological surgery already exists, and there have been fellowships in dermatological surgery for over 20 years. Prior to my otolaryngology residency, I was director of cutaneous surgery and the dermatological surgery fellowship in the department of dermatology at the University of Iowa. Not only did the fellow do

LETTERS, continued

all the procedures you mentioned except for liposuction, but the residents did as well, but not to the same degree. They developed the analytical skills to know when to apply the techniques and how to manage the patients postoperatively.

You comment that such a program would "create 'surgeons' who could perform a much broader range of operations including hair replacements, tumescent liposuction...." Hair replacement techniques such as punch grafts and mini and micro grafts were developed and perfected by dermatologists, as was the tumescent

liposuction technique. All the procedures you refer to are procedures dealing with the skin. The knowledge of the physiology and of the pathology of the skin is the realm of the dermatologist.

The issue of the lack of peer review since this is outpatient surgery is a red herring. Overall the medical community has never done peer review well. In recent years, I know of physicians granted FACS status who were not considered ethical or competent by their peers. We all know well the legal quagmire of peer review, so that it is often sidestepped.

Dermatology residents learn the

evaluation and treatment of patients throughout their residency, as do surgical residents. Granted there is different emphasis related to the specialty, as there is in all surgical subspecialties.

What would constitute an appropriate dermatological surgery fellowship? Should it be two years? Should there first be a preliminary year or two of general surgery as with most surgical subspecialties? An exception to this is ophthalmology, which does not require that rite of ordeal.

Frank C. Koranda, MD, FACS

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Highlights of the Board of Regents meeting

February 9-10, 2001

by John P. Lynch,
Director,
Organization Department

Financial report

The Board of Regents reviewed and approved several recommendations from its Finance Committee. For example, it approved the extension of a contract with Cambridge Associates, Inc., the investment advisor to the College, and business plan guidelines for new College programs. In order to be considered for funding and approval, new ACS programs must have a business plan, a budget, and authorization from both the Finance Committee and the Regents.

The Regents approved the Finance Committee's recommendations on the roles and responsibilities of the Board and its committees and staff, investment consultants, and managers and custodians of the College's investment assets. The Regents also adopted an ACS Statement of Investment Objectives and Policies and a Code of Conduct Policy, which includes a conflict of interest policy for employees and College consultants.

Conference on medical simulation

The Board of Regents approved a recommendation that the College sponsor a computer simulation working conference during the summer of 2001. The conference will be hosted by Boston College's Center for the Study of Testing, Evaluation, and Education Policy. It will examine mechanisms for demonstrating that computer simulations can improve patient care and surgical education. The College will partially fund the conference and will seek additional support from outside sources.

CME joint sponsorship program

The Board approved the development and implementation of a continuing medical education (CME) joint sponsorship program within the College's Office of Continuing Medical Education. The program is being de-

veloped to meet the needs of Fellows who are members of other surgical organizations by providing a mechanism to award CME credit for surgeons who participate in CME activities sponsored by those organizations. The program will enhance relationships with regional surgical societies by providing a cost-effective mechanism for these organizations to grant CME credit to their memberships.

Committee on Emerging Surgical Technology and Education

The committee is sponsoring two clinical trials in hernia management. The first, comparing laparoscopic and open hernia repairs, has received more than 50 percent of its projected accrual. The second, comparing watchful waiting and operation, has enrolled about one-third of the projected sample. The trials are scheduled to be completed in 2004-2005.

Graduate Medical Education Committee

The committee presented its annual Surgeons as Educators Workshop January 20-26 in Gainesville, FL, and is planning a Residents As Teachers Workshop. The committee also intends to offer "A Day at the American College of Surgeons" for minority students from inner-city high schools in New Orleans, LA, during the 2001 Clinical Congress. The first such program was held during the 2000 Clinical Congress in Chicago, IL, with 150 students, their teachers, and program coordinators attending a day-long program of student mentoring activities.

Surgical Research and Education Committee

The committee's third course in Clinical Trials Methods took place November 9-14 at the

ACS headquarters in Chicago, IL; 50 participants and 14 faculty attended.

Candidate and Associate Society

The Candidate and Associate Society met in October during the Clinical Congress. The society's Council of Representatives, drawn from 51 chapters, met to organize and develop specialty-specific agendas, appoint representatives to the College's Advisory Councils for the Surgical Specialties, and assign members to the society's committees. Approximately 130 of the Council's 207 positions have been filled. Ninety-one council members attended the organizing meeting in Chicago. The society's Executive and Issues Committees are developing a draft parental leave statement, and the CAS is closely examining various aspects of the resident work hours issue.

Advisory Councils for the Surgical Specialties

The 12 Advisory Councils for the Surgical Specialties continue to develop specialty-sponsored programs for presentation at the Clinical Congress and the Spring Meeting. They also continue to submit specialty articles for publication in the *Journal of the American College of Surgeons* and are becoming more involved with socioeconomic issues that affect all surgical specialties, including Medicare reimbursement and graduate medical education.

Joint Commission on Accreditation of Healthcare Organizations

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has identified five strategic priorities, including patient safety, improving the value of accreditation, becoming an information company, engaging physicians in the accreditation process, and establishment of evidence that standards and performance measures—and accreditation as a whole—improve the safety and quality of care.

Council of Medical Specialty Societies

The Council of Medical Specialty Societies (CMSS) has approved several recommen-

dations regarding the American Board of Medical Specialties (ABMS)/CMSS Joint Planning Committee that is working on the physician competence initiative. The Joint Planning Committee now is expected to consider issues that relate to the development of joint programs and activities that require input from both organizations' members, such as development of CME mechanisms and programs and formulation of physician outcome assessment programs.

Board of Governors' committees

The Regents reviewed several recommendations from the Board of Governors' committees. For instance, the Regents approved a recommendation to establish a Regental Committee on Minority Issues, which will study educational, professional, and health-related issues of under-represented minority surgeons and patients. The Regents also endorsed the Governors' Consensus Statement of the Physician Leadership on National Drug Policy relating to addiction to illegal drugs.

In a previous action, the Executive Committee of the Board of Regents reviewed the Board of Governors' recommendation that the Board of Regents consider forming a political action committee (PAC). This issue was referred to the recently formed Health Policy Steering Committee, which includes representation from the Board of Governors.

Patient Safety and Professional Liability Committee membership

The Regents approved plans to expand the membership of the Patient Safety and Professional Liability Committee. The committee will add the chairs of the Committee on Emerging Surgical Technology and Education, the Committee on Operating Room Environment, and the Board of Governors' Committee on Ambulatory Surgical Care as ex officio members to better coordinate the College's patient safety activities. Also, the status of the College's representative to the Patient Safety Foundation will be changed

from consultant to full member. In another activity, a proposal for the new *Patient Safety Manual* has been signed.

Legislative and regulatory update

Letters of invitation have been sent to 16 Fellows to join the newly established ACS Health Policy Steering Committee. The committee will identify public policy issues and concerns affecting surgeons and their patients, prioritize these issues and concerns, and identify those on which the College should focus its attention and resources and recommend these priorities to the Board of Regents. The committee also will develop action plans for addressing these issues and generate and maintain mechanisms by which legislative and regulatory issues can be addressed in a timely and effective manner.

In addition, the College has joined 40 other national medical organizations in sending a letter to the Health Care Financing Administration (HCFA) regarding its plans to publish new proposed regulations to expand the scope and breadth of the Emergency Medical Treatment and Labor Act (EMTALA). The letter discussed how the continual expansion of EMTALA is seriously straining the ability of the medical profession to provide quality care—as evidenced by overcrowded emergency rooms and reduced access to critical specialty emergency care. The letter urged HCFA to refrain from issuing further EMTALA regulations until the Government Accounting Office study of EMTALA is completed.

Further, during the final days of the 106th Congress, President Clinton signed a law that included \$3 million in fiscal 2001 funding for the Trauma Care Systems Planning and Development Act. The law authorizes the Secretary of Health and Human Services to award grants to states to assist them in planning, implementing, and monitoring statewide trauma care systems. The College will be working with both the new administration and Congress to further the goals of

the original trauma program that was administered during the mid-1990s by the Health Resources and Services Administration (HRSA) Division of Trauma and Emergency Medical Services. The College will work with the new HRSA Administrator to establish a timely plan for administering the program and reviewing state applications for trauma system grants.

The College continues to encourage its chapters to assist in recruiting Fellows to participate in its Congressional Action Program, an initiative designed to develop and strengthen individual relationships between Fellows and congressional leaders and staff. Washington Office staff have visited 11 chapters since the program was initiated and have recruited approximately 200 Fellows for the program.

The ACS Health Policy and Advocacy Department continues to support College Fellows who serve on their state Medicare Carrier Advisory Committees (CACs). CAC members have been identified in all 50 states and the District of Columbia. An informational forum for ACS CAC members was held April 22 in conjunction with the ACS Spring Meeting in Toronto, ON.

AMA House of Delegates Interim Meeting

The Regents reviewed information on the actions taken at the American Medical Association (AMA) House of Delegates Interim Meeting, December 3-6, 2000. The College was represented by a full complement of five delegates. Immediately before the meeting, the Surgical Caucus met for a full discussion of office-based surgery and to review other House of Delegates business of interest to surgeons. Seventeen surgical delegations with 34 delegates sat together as a group during the House of Delegates meeting.

The College submitted a resolution titled, "HCFA Staff Contact for Specialty Societies," which asked the AMA to meet with HCFA to insist on the Agency's hiring a principal physician contact/liaison within HCFA

for medical specialty societies, carrier medical directors, and regional reimbursement specialists. This resolution was adopted by the House. Another College resolution, "Physician Information on Third-Party Payor Performance," asked the AMA to investigate the development of a national data warehouse or repository of information collected from physicians and their offices on third-party payor performance. This resolution was referred to the AMA Board of Trustees for decision.

Two resolutions calling on the AMA to study the issue of patient safety in office-based surgical facilities, including issues of accreditation, access to care, and need for guidelines that could be developed by the AMA, were referred to the Board of Trustees. The College was very vocal in promoting its *Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery* and offered to work with the AMA on this issue.

ACS National Cancer Data Base

The College's National Cancer Data Base (NCDB) currently contains data on approximately 9 million cancer cases. Data are provided to the NCDB by 1,500 hospitals participating in the Commission on Cancer Approvals Program. Participation in the data collection activities became a requirement for approval in 1996. As a result, it is estimated that 80 percent of cancer cases diagnosed in 2000 will be reported to the NCDB.

American College of Surgeons Oncology Group

The American College of Surgeons Oncology Group report indicated that the move to Duke University Medical Center was completed successfully on January 1, 2001. The facilities of the Duke Clinical Research Institute (DCRI) are excellent, and the administrative personnel in the DCRI, the department of surgery, and the Duke University Medical Center were most helpful during the relocation of this College program. Patient accrual remains strong in the program's open trials.

Central Judiciary Committee Process

The Regents reviewed the College's Central Judiciary Committee (CJC) process. The committee is responsible for the general supervision and direction of disciplinary matters under the Board of Regents. The CJC consists of five Fellows of the American College of Surgeons, three of whom are Regents. Members of the CJC are appointed by the Board and serve such time as their successors are appointed and qualified. The foundation for disciplinary procedures followed by the committee is found in the ACS *By-laws*.

Journal of the American College of Surgeons (JACS)

JACS is now mailed as a membership benefit to all ACS Fellows, Candidates, and Associate Fellows. To address the interests of this broader readership, the material in *JACS* has been diversified. In addition, a significant expansion of the electronic presentation of the *Journal* has occurred. It is readily accessible from the College's Web site.

An interactive CME program is now available, providing 24 CME category 1 credits each year. Print copies of *JACS* contain two CME questions from two articles each month. The Web site offers four CME articles with two questions each, including the critiques.

Communications activities

The Regents approved a statement delineating Guidelines Governing the Acceptance of Commercial Advertising and/or Sponsorship for Programs of the American College of Surgeons Web Site. The statement is modeled on guidelines published last year by the AMA.

Additionally, a complete redesign of the ACS Web site has been completed. Traffic on the Web site remains heavy and continues to grow, with the number of hits per day reaching 10,510. In another activity, consumer interest in the College's public infor-

mation brochures continues. Last year, approximately 12,000 copies of the brochure *When You Need an Operation* were distributed by the College.

ACS Development Program

Gifts and pledges received during 2000 totaled \$1,374,967. The Fellows Leadership Society added 21 new Life Members (gifts or pledges of \$10,000 or more), and major gifts received during the year included a \$100,000 charitable trust and an outright gift of \$75,000.

Scholarships Committee recommendations

The Board of Regents approved recommendations from the Scholarships Committee to award 10 ACS Faculty Research Fellowships for 2001-2003. The Fellowships are provided to assist surgeons in establishing new and independent research programs. The Fellowship Award is \$40,000 per year for each of two years to support the research efforts.

Working Group on Archives and Properties

The Regents approved a request for finances to update presidential portraits and wall lists in the ACS headquarters building and for ongoing acquisition of art pieces for decorating public spaces. The committee is studying the feasibility of developing a surgical heritage center in either the Nickerson Mansion or the J.B. Murphy Memorial Auditorium.

Working Group on Membership and Membership Benefits

In a preliminary report, the working group indicated that it is attempting to identify current ACS services that benefit specialty and subspecialty members of the College and to identify services that would make Fellowship more attractive. A more comprehensive report will be presented to the Board of Regents in June.

Working Group on Education

This working group recommended that the College establish a Division of Medical Education within the College's organization structure and that the ACS initiate a search for a qualified medical educator to head this division. The Board of Regents approved this recommendation. The working group sponsored a Strategic Planning Conference for Education immediately following the Board of Regents meeting.

Internal Task Force on Evidence-Based Medicine

A report from this task force examined the issue of establishing an Office of Evidence-Based Medicine within the College's administrative structure. The task force emphasized that the primary focus of such an office should be outcomes measurement. Because the College has a unique ability to assess surgeons and surgical data, it could become a major provider of information regarding surgical practice and the outcomes of surgical care. The report also stressed that the College should partner with other organizations that are active in this field. Creation of such an office will require investment in a data management system and appropriate personnel, and development of a management infrastructure. The Regents asked that a more detailed business plan be developed for creating such an office and be presented at a future Board of Regents' meeting.

ABS/ACS Joint Committee on Competence

The American Board of Surgery (ABS)/American College of Surgeons Joint Committee on Competence have agreed that the ABS should develop a curriculum and the ACS should develop a complementary self-assessment instrument to provide the necessary teaching and self-assessment components of the various competencies recently adopted by the ABS. It was also agreed that the ACS self-assessment instrument should

Highlights of the Board of Regents meeting

emphasize the competencies of patient care and medical knowledge and include selected aspects of professionalism (including ethics), systems-based practice, practice-based learning and improvement, and interpersonal communications skills. All specialty boards and societies have shared interest in developing relevant educational activities in these areas. The Regents approved further investigation of these areas of agreement.

Report of the Executive Director

Thomas R. Russell, MD, FACS, ACS Executive Director, presented a brief report highlighting major accomplishments during the past year, including multiple chapter and

surgical society visits, formation of the Health Policy Steering Committee, initiation of the strategic planning process, expansion of the nomination process for Regental and Officer positions, and improved communications links between the Executive Director, the Boards of Regents and Governors, the Specialty Advisory Councils, and the committees of the College.

Effective Board governance

At the conclusion of the meeting, the Board of Regents engaged in a presentation and discussion with a management consultant on the subject of effective Board governance.

The *Journal* page

Message from the Editor

by Seymour I. Schwartz, MD, FACS, Rochester, NY

The direction of the *Journal of the American College of Surgeons* can be defined in the word "diversity." As a consequence of the expanded readership, which pertains not only to numbers but also to a spectrum of interests, changes in the published editorial material are required. Articles on diverse subjects are required to satisfy a diverse audience.

The June issue of the *Journal* includes contributions from two distinguished oncologists, Dr. Cady and Dr. Veronesi, whose impact on the field of breast surgery has extended over several decades. Their view of the current scene in oncology is based on the broad perspective of experience and long-term involvement.

At the other end of the spectrum, articles on the relationship of the economy and the surgical suite

and on the effects of DRGs on academic health centers address issues that have evolved more recently. Thus, bound in a single issue are voices that have spoken in the past to address the current status of a specific and important field, and a consideration of current societal influences on the practice and educational mission of surgery. These subject matters transcend all surgical specialties. Within the covers of the June issue, as will be policy for future issues, diversity is demonstrable.

Dr. Schwartz is Distinguished Alumni Professor, University of Rochester (NY) School of Medicine and Dentistry. He is also Editor-in-Chief of the Journal of the American College of Surgeons and a Past-President of the College.

INTRODUCTORY ABSTRACT from the June lead article

Trocar Injuries in Laparoscopic Surgery. Sunil Bhojral, MD FRCS (Eng), Mark A Vierra, MD, FACS, Camran R Nezhat, MD, FACS, Thomas M Krummel, MD, FACS, Lawrence W Way, MD, FACS. From Scripps Clinic Medical Group, La Jolla, CA (Bhojral), the departments of surgery, Stanford University School of Medicine, Stanford, CA (Vierra, Nezhat, Krummel), and University of California San Francisco School of Medicine (Way).

Background: Disposable trocars with safety shields are widely used for laparoscopic access despite a recognized risk of injury to abdominal viscera. The aim of this study was to analyze risk factors associated with trocar injuries reported to the FDA.

Study design: Manufacturers are required to report medical device-related incidents to the FDA, whose records through 1996 are currently available on the Internet. We analyzed all such reports and identified 629 relevant trocar injuries from 1993 through 1996.

Results: There were 3 types of injury: 408 injuries of major blood vessels; 182 other visceral injuries (mainly bowel injuries); and 30 abdominal wall hematomas. Of the 32 deaths, 26 (81%) resulted from vascular injuries and 6 (19%) from bowel injuries. Eighty-seven percent of deaths from vascular injuries involved the use of disposable trocars with safety shields, and 9% involved disposable trocars with a direct viewing feature. The aorta (23%) and inferior vena cava (15%) were the vessels most commonly traumatized in the fatal vascular injuries. Ninety-three percent of major non-fatal vascular injuries involved disposable trocars with safety shields, and 7% involved direct-view trocars. There was an associated bowel injury in 10% of vascular injuries. Twenty-seven vascular injuries (7%) occurred when the trocar was inserted in the absence of a pneumoperitoneum or when extra force was required during introduction of the trocar. In 41 patients (10%), the surgeon initially thought the trocar had malfunctioned, but in only one instance was malfunction subsequently

confirmed when the device was examined. Ninety-one percent of bowel injuries involved trocars with safety shields, and 7% involved direct view trocars. The diagnosis of an enterotomy was delayed in 10% of patients, and the mortality rate in this group was 21%. The likelihood of injury was not related to any specific procedure or manufacturer.

Conclusions: These data show once again that safety shields and direct view trocars cannot pre-

vent serious injuries. Vascular injuries are more likely to be fatal if they involve the aorta or inferior vena cava. By comparison with the other categories, these retroperitoneal vascular injuries are largely avoidable by following recognized guidelines for safe trocar insertion. Bowel injuries often go unrecognized, in which case they are highly lethal. Device malfunction is rarely implicated as a cause.

RURAL SURGERY, from page 19

Conclusion

In all, surgeons seem to derive a great deal of personal and professional satisfaction from practicing in nonmetropolitan areas. This sense of reward continues to increase as rural hospitals expand to offer more regionalized care.

Nonetheless, the problems long associated with rural health care persist. Some of these challenges might be eased as telemedicine expands the opportunities for surgeons to work together on cases from afar and Web-based learning becomes more commonplace. The landscape of rural health care

will, no doubt, continue to change and become more impressive in the coming years. 

References

1. Federal Office of Rural Health Policy: Facts about...Rural physicians. FORHP Web site: http://www.shepscenter.unc.edu/research_programs/Rural_Program/phy.htm.
2. National Rural Health Association: Physician recruitment and retention. NRHA Web site: <http://www.NRHArural.org/dc/issuepapers/paper13.htm>.
3. Wall J: Medical mentors in rural Oklahoma. *Sooner Magazine* 20(3):4-8, 2000.

Coding workshops

The College will be hosting coding workshops for the first half of 2001. We have a new one-day format, for all surgeons, with a new consultant. The program, Coding and Documentation: The Keys to Reimbursement, will present both CPT and ICD-9-CM coding for surgeons and their office staff that is basic to intermediate. The program will include an interactive networking lunch to assist in meeting other colleagues with similar coding issues. Earn eight Category I CME credit hours.

Dates and locations:

May 27, 2001	Hilton San Francisco, CA
June 9, 2001	Caribe Hilton, San Juan, PR
June 22, 2001	ACS Headquarters, Chicago, IL
June 23, 2001	Lake Lawn Resort, Delavan, WI

For further registration information, contact the Health Policy and Advocacy Department at 202/337-2701, fax 202/337-4271, e-mail HealthPolicyAdvocacy@facs.org.